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COUNTIES MANUKAU HEALTH

Annual Plan

2021/22

Cover photograph: Mangere Mountain – Te Pane o Mataoho

2021/22 Annual Plan incorporating the 2021/22 Statement of Performance Expectations

Presented to the House of Representatives pursuant to sections 149 and 149(L) of the Crown Entities Act 2004 and section 38 of the New Zealand Public Health and Disability Act 2000

He Pou Koorero

(A Statement of Intention)

Ko te tumanako a tenei poaari he whakarato i teetahi o ngaa taupori Maaori nui, taupori Maaori matatini, puta noa i te motu. Ko te whakakikokiko i te mana-taurite hauora Maaori teetahi o aa maatou tino whaainga.

Ko too maatou hiahia ko te whakamana, ko te whakatinana hoki i te wairua me ngaa maataapono o Te Tiriti o Waitangi hei tuuaapapa i taa maatou e whai nei, me te whakapono nui - maa te aata whakapakari i te ara whakawaiora Maaori e taea ai te whakatutuki i te mana taurite hauora moo te katoa.

As a District Health Board we serve one of the largest and most diverse Maaori populations in the country. Achieving Maaori health equity is a key priority for us.

Our commitment to this is driven by our desire to acknowledge and respect the Treaty of Waitangi and our belief that if we are serious about achieving health equity for our total population, we must first strengthen our commitment and drive to accelerate Maaori health gain in our community.

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Minister's 2021/22 Letter of Expectations to Counties Manukau DHB

Hon Andrew Little
Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

10 FEB 2021

Vui Mark Gosche
Chair
Counties Manukau District Health Board
Mark.Gosche@middlemore.co.nz

Tēnā koe Vui Mark

Letter of Expectations for district health boards and subsidiary entities for 2021/22

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2021/22. As a DHB Chair you are accountable to me for meeting these expectations.

This government acknowledges the progress made to rebuild our health system, but there is still more to do. It is clear that COVID-19 will be placing a range of pressures on our health system for some time. We are well placed to continue to respond to resurgence as needed and to lock-in new ways of operating based on our COVID-19 response so that we retain and embed new and innovative approaches where possible.

A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities, and this will be a key piece of work for the health system during 2021/22. Additional information will be provided when it becomes available.

As you know the Government has accepted the high-level direction of travel of the Health and Disability System Review (HDSR) and during this next phase we will roll out our plan to improve the public health system to ensure it delivers high quality services, improved equity for our vulnerable populations and supports better outcomes for all New Zealanders.

There will be uncertainty ahead, but I expect that this will not stop you from driving forward and continuing to deliver the improvements already underway. It is important that the sector continues to function at its best to provide health and disability services for New Zealanders while system changes are being confirmed and implemented. I also expect that you will begin to work together on further enhancements. The work we do now will ensure we have the right models of care to support longer term sustainability and to maximise outcomes through robust investment in primary and community care.

The priorities this Government has previously outlined to guide DHB planning will remain of critical importance for the coming year. Our wellbeing and equity system priorities together with a focus on giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025 and improvements to DHB sustainability, continue to provide a solid framework for planning and articulating the work DHBs are doing:

- giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025
- improving sustainability
- improving child wellbeing
- improving mental wellbeing including a focus on the transformational direction for our approach to mental health and addiction through the agreed actions from the Mental Health and Addiction Inquiry

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- improving wellbeing through prevention;
- better population outcomes supported by a strong and equitable public health and disability system
- better population health and outcomes supported by primary health care.

I would like you to continue to build on these areas of focus, so we improve equity for our vulnerable populations while also ensuring COVID-19 lessons and innovations are captured.

I expect all DHBs to deliver breakeven results by the end of 2021/22 and your annual plan will not be supported without this commitment. Strong fiscal management is critical to support our collective ability to invest more in new models of care and in primary care and population prevention approaches.

It is also imperative that the health system maintains and continues to strengthen our health capital planning, investment and delivery and as Chair you must have clear oversight of the DHB's annual plan to ensure it is sustainable, person centred and reflects Government expectations, including breakeven financial targets.

As you will be aware the Government will be implementing recommendations from the Health and Disability system review. This work will be undertaken alongside the work laid out in this letter. I expect that all DHB's will continue to provide the highest quality services to their populations while any changes are implemented across the system.

A number of DHBs will benefit from expert support across a range of areas and I understand that Chairs are working on an exemplars group. I expect you to seek the support of your colleagues and the Ministry where you need a lift in capability or support to navigate specific challenges.

This Government has provided specific sustainability funding for DHB led improvement projects. I expect to see tangible outcomes being delivered and implemented with this funding and reports on the impact it is having.

You will be aware that pay parity for workforces in the DHB-funded sectors is an issue. This is also an issue in other parts of the State sector, and it is important that a whole-of-Government approach is taken. This Government's position will be developed at a central agency level and I expect you to contribute to and act consistently with this approach. There are complex matters that need careful consideration, including whether DHB funding has flowed equitably to employees in the past and how this would be protected in the future.

I expect all DHBs to increase the pace and scale of implementation of the Care Capacity Demand Management Programme (CCDM) in 2021 to meet the expectations outlined in the 2018 NZNO DHB MECA. I want to be clear that full implementation of CCDM includes annual FTE calculations and ensuring agreed budgeted nursing and midwifery FTE are in place.

DHBs are responsible for the health outcomes for your population and it is important that DHBs and the Ministry continue to work together, and with primary and community providers, to ensure we have a strong and equitable public health system delivering better health outcomes for our most vulnerable populations who have long-standing health inequities.

Please ensure any approaches to a service reconfiguration support improved access to care and equity, and are financially sound. As you are aware any shifts or additions in workforce / FTE must be considered as a service change and follow service change processes. DHBs

must remain focused and prepared for increased pressure and ensure systems are in place to ensure COVID-19 innovations are used to avoid pressure building up on existing services.

DHBs are expected to support and contribute to the Ministry's National Asset Management Programme (NAMP), which will be used to assist the Capital Investment Committee and Ministers to make more informed decision on DHB capital expenditure. I expect DHBs to develop their own Asset Management Policy and Strategy and align their asset management practices with the Ministry of Health district health board sector Asset Management Framework.

Unlike previous years I have strong expectations that the annual planning process will be completed on time and as Chair it is your responsibility to meet all deadlines for this process. I expect a strong first draft annual plan will be provided to the Ministry for review in early March so that a robust final plan that meets all expectations will be able to be agreed with me as early as possible post Budget 21. If timelines are not met and robust and appropriate plans are not delivered I will not be able to sign them off for the year.

Please note that I do not require you to refresh your Statement of Intent for 2021/22.

We face complex challenges that require collective approaches and I am looking forward to working with you as we continue our efforts to improve outcomes for New Zealanders.

Thank you for the work you have been doing to provide strong governance within our health system. I remind you that in everything you do you are part of the system.

Ngā mihi nui

Hon Andrew Little
Minister of Health

Cc Fepulea'i Margie Apa
Chief Executive
Counties Manukau District Health Board

1. Overview of strategic priorities

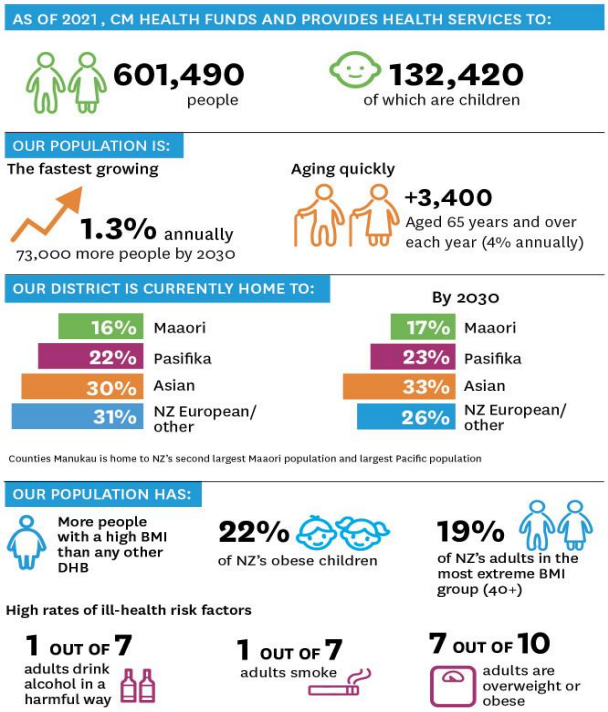
1.1 Strategic intentions and priorities

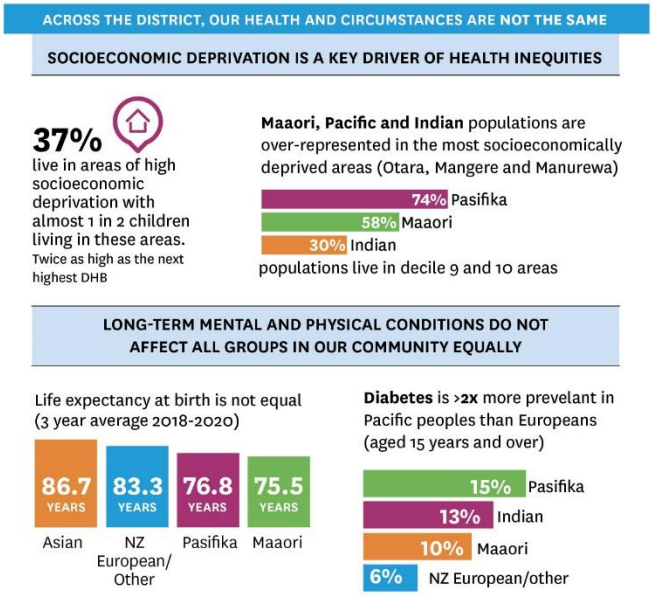
The communities we serve

Counties Manukau District Health Board is one of twenty district health boards established under the New Zealand Health and Disability Act 2000 (NZPHD Act 2000) to plan and fund the provision of personal health, public health and disability support services for the improvement of the health of the population.

The Counties Manukau District Health Board provides and funds health and disability services to an estimated 601,490[1] people in 2021 who reside within the district boundaries. Counties Manukau is one of the fastest growing district health board populations in New Zealand with a youthful and ageing population.

The Counties Manukau population is diverse and vibrant with strong cultural values. Counties Manukau is home to New Zealand's second largest Maaori population, largest population of Pacific peoples, as well as fast growing Asian communities.





Across the Counties Manukau district, health outcomes and experiences of health across communities are not the same. Thirty-seven percent of the population live in areas of high socioeconomic deprivation (NZDep2018 9&10[2]). Over 132,000 children live in Counties Manukau, with almost 1 in 2 living in areas of high socioeconomic deprivation. By 2030, the Counties Manukau district is forecast to be 17 percent Maaori, 23 percent Pacific, 33 percent Asian and 26 percent NZ European/Other ethnicities. There are persistent gaps in life expectancy between Maaori and Pacific peoples and others living in Counties Manukau.[3] Ootara, Maangere, Manurewa and Papakura, home to many Maaori and Pacific communities, are the most socioeconomically challenged areas in the district.

Long-term mental and physical conditions do not affect all groups in the community equally[4]. The population experiences relatively high rates of ill-health risk factors (such as smoking, obesity, hazardous alcohol use) that contribute to a 'package' of long term physical conditions which are responsible for the majority of potentially avoidable deaths. Increasing the number of people living smokefree and free from the harms of hazardous alcohol use, improving nutrition and physical activity and reducing obesity are key to improving the health of the Counties Manukau population.

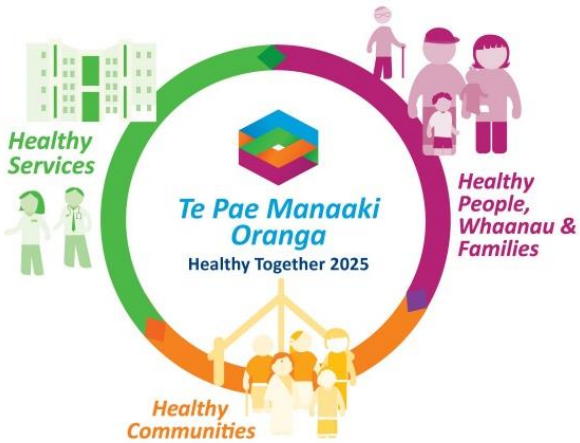
[1] Unless otherwise referenced, population data is sourced from the District Health Board Ethnic Group population projections (2018-Census Base) – 2020 update.
[2] New Zealand Index of Deprivation (NZDep) is an area-based measure of socioeconomic deprivation. It measures the level of deprivation for people in each small area. It is based on nine Census variables. NZDep can be displayed as deciles or quintiles. Quintile 5, or deciles 9 and 10, represents people living in the most socioeconomically deprived 20 percent of these areas.
[3] Life expectancy in Counties Manukau 2020; unpublished analysis Counties Manukau Health 2021.
[4] E.g. Winnard D, Papa D, Lee M, Boladuadua S et al (2013) populations who have received care for mental health disorders. CM Health, Auckland

Strategic Direction – Te Pae Manaaki Oranga[5]

Life expectancy and other population health indicators have improved, and will continue to improve, for most communities that live in the district under the current settings. However, the gaps in life expectancy and other indicators of health for Maaori and Pacific people, when compared with other groups, persist and are stark.

The DHB's strategic goal Te Pae Manaaki Oranga – Healthy Together 2025 is:

"Together with others, Counties Manukau Health will enable equity in access and outcomes for Maaori, Pacific and other communities with health disparities"



This Annual Plan represents year 1 of a 5-year implementation roadmap. Te Pae Manaaki Oranga builds on the partnership with Mana Whenua i Taamaki Makaurau to improve the part the health system can play to enable people, their whaanau and communities to live well and fulfil their potential. The health system aims to add healthy life years to the experience of local communities measured through a range of population health improvement indicators.

Te Pae Manaaki Oranga has three key objectives:

Healthy Communities: add healthy life years by advocating for settings that reduce tobacco and alcohol harm, work better with inter-sectoral partners to advance social wellbeing and promote environments that enable healthy nutrition, physical activity and weight;

Healthy People, Whaanau and Families: add healthy life years by improving the experience of people and their whaanau to access the care they need in communities closer to home, enabling partnership in that care and improving their reported experiences of care across both community and hospital care;

Healthy Services: improve the experience of health workers by developing the CM Health workforce, advocating for and investing in infrastructure (facilities, technology, equipment), supporting a culture that enables health workers to do their best, and recruiting, developing and retaining a diverse workforce that reflects the community we serve.

CM Health see great opportunity to improve health in this coming year but there are challenges.

Challenges in the 21/22 year

There are many challenges that continue into this financial year that have continuing impacts on the district.

COVID-19 – keep it out, stamp it out, prevent it It is expected that all three strands of pandemic response will be activated in this financial year within the district. The Northern region continues to operate the most significant 'keep it out' part of the response in providing health testing and care at the border (airport and ports) and in managed isolation and quarantine facilities. 4,000 beds and their guests across 16 hotels in the region represents more than half of the country's capacity to keep out the virus. The Northern region operates an outbreak management response when virus is detected in the community. Over 20/21 the Northern region has deployed both DHB staff and NGOs/providers (community) to stand up rapid testing and support contact tracing of people potentially infected by virus. The 21/22 year will be dominated by efforts to vaccinate the population with newly developed vaccine and support informed consent and reduced hesitancy by encouraging communities to get engaged. These initiatives will represent a major rate limiting factor on the DHB's ability to manage 'business as usual' healthcare delivery and reduce risk of deferring or delaying care.

Obesity, long term conditions and mental health The increasing prevalence of long term physical and mental health conditions is one of the major drivers of healthcare demand for the DHB. The rapid implementation of local initiatives such as Te Ranga Ora and regional collaboratives such as Tu Whakaruruhau (primary mental health) must be accelerated

[5] Te Pae Manaaki Oranga is about community aspiration in the pursuit of health and wellbeing. The definitions behind the kupu Maaori of Te Pae Manaaki Oranga are: **Te Pae** is the broader context; the underpinning of social, community and cultural principles. **Manaaki** is CM Health's stance of guardianship. **Oranga** is fulfilment of wellness, to be well.

to be impactful on this group of people. This is particularly challenging in the context of the COVID-19 related demands on the health system.

Growing and ageing population Counties Manukau is the fastest growing DHB and the population is forecast to increase by 73,000 people by 2030. The population is also ageing with four percent more people aged 65 years and over in the Counties Manukau population every year. This group will place high demands on health and disability services in the years to come and is a challenge particularly significant for the Franklin and Eastern localities. Initiatives already in place that support people to age well at home and/or in communities that support them are important to advance this coming year.

Large high-needs population Socioeconomic deprivation is a key driver of health inequities. In 2021 it is estimated that over 220,000 people in Counties Manukau, over a third of all residents, are living in areas classified as being the most socioeconomically deprived in New Zealand. This is many more people living in these circumstances than any other DHB in New Zealand and this presents a challenge for health and social sector agencies to best support people to flourish. The opportunities for agencies to work better together through collaboratives such as the Social Wellbeing Board is significant for all agencies to do better.

Year 1 of Te Pae Manaaki Oranga

Te Pae Manaaki Oranga and this Annual Plan work in alignment with national strategies that are understood to be current:

- Te Tiriti O Waitangi (the Treaty of Waitangi)
- the New Zealand Health Strategy
- He Korowai Oranga and Whakamaua 2020-25
- the Healthy Ageing Strategy
- the New Zealand Disability Strategy 2016-26
- the UN convention on the Rights of Persons with Disabilities and the Disability Strategy
- Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025.

Te Pae Manaaki Oranga is developed in partnership with Mana Whenua i Taamaki Makaurau and in consultation with consumers as represented by the Consumer Council, staff, PHO and NGO representatives. A significant focus for the DHB in the 21/22 year will be in 'keeping out, stamping out and preventing' COVID-19 and on enacting the changes resulting from the Health and Disability Review reforms announced in May 2021.

Responding to the challenge – Every hour counts, every dollar counts and we must choose wisely

Since Healthy Together was published in 2015, funding and revenue growth has been outpaced by population growth and increasing demand for healthcare. Trade-off decisions and a commitment to cost reduction and optimisation have enabled progress towards living within our means. Cost reduction opportunities are increasingly challenging, accordingly greater emphasis is now dedicated to achieving best value from existing capacity and capability, in turn slowing the requirement for additional capacity. Securing a fair share of revenue relevant to the needs of the local population will remain a focus.

The demand for healthcare associated with a growing, ageing and changing population is quickly outstripping the supply of workforce needed to deliver services using current models of care. We are constantly challenged to optimise use of our largest asset to deliver care in alternative ways to meet demand.

CM Health is also faced with ageing facilities infrastructure. The average age of the DHB buildings is 40 years and certain buildings are not suitable for future long-term use. National funding and affordability constraints over previous years has resulted in significant deferral of key hospital building maintenance resulting in a need to urgently remediate facilities and seek significant investment in capacity expansion. Recent government investment in remediation and facilities expansion has been welcomed; however, continued investment is necessary to ensure the DHB facilities remain fit for purpose into the future. CM Health's Statement of Performance Expectations outlines regionally prioritised major capital investments that will add critical service capacity, as well as remediation of health and safety and clinical service risks due to aging facilities infrastructure.

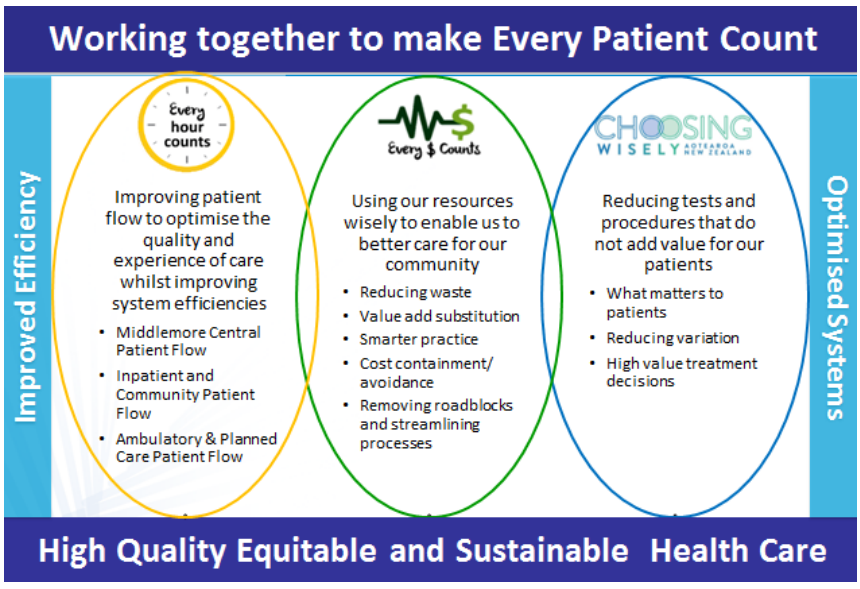
Throughout 2020/21 CM Health has continued to respond to the significant ongoing requirements in relation to COVID-19 which has seen continued deployment of a significant number of staff away from normal roles. The urgency and ongoing nature of this activity has impacted the delivery of the DHBs strategic programmes to achieve best value from the health system, including the Every Dollar Counts sustainability programme. Recovery of planned care and ensuring available capacity to meet acute demand growth will be an ongoing challenge for 2021/22.

Within this context, priorities for 2021/22 are to continue towards a planned reduced deficit position by:

- constraining cost growth to do more with current resources enabled by rapid deployment of flow improvement initiatives (Every Hour Counts)
- enabling technologies to reduce time wasted and improve workflows and targeted investment within funding constraints to high risk clinical services in both community and hospital services
- reinvigorating the Every Dollar Counts programme where the resources required to implement savings initiatives were deployed to managing emergency incidents
- an expanded regional work programme with the Northern Region DHBs to seek further collaborative opportunities
- offset by continued demand in relation to COVID-19, expanded in full in section 2.6

The Every Hour Counts, Every Dollar Counts and Choosing Wisely portfolios of work support CM Health's strategic aims of achieving high quality, equitable, sustainable healthcare for patients, community and staff:

- ***Every Hours Counts*** will optimise patient flow by working smarter with the systems and resources that exist within the organisation e.g. linking testing and appointments on the same day to save patients' and staff time.
- ***Every Dollar Counts*** will reduce/avoid costs and protect revenue streams e.g. improving



clinical documentation to optimise revenue for the care provided to patients.

- ***Choosing Wisely*** will reduce unnecessary tests and procedures that do not add value to patients and staff.

These programmes of work operate across the organisation and, in some areas, across the healthcare system to support health workers to improve system performance by:

- working with teams to diagnose and design systems, services and processes that enable patients to receive the right care, in the right place, at the right time.
- reduce inequities in the system; privileging health equity for Maaori, Pasifika and those with health disparities.
- improving the experience for those delivering and receiving care.
- reducing harm, waste, duplication, fragmentation and inappropriate variation.
- developing a culture of continuous quality improvement and learning, at both a service and system level.

Te Tiriti o Waitangi

Counties Manukau DHB aims to fulfil its obligations as agent of the Crown under the Te Tiriti o Waitangi (Treaty of Waitangi). Our relationship with the tangata whenua of the district is expressed through a board-to-board relationship with Mana Whenua i Taamaki Makaurau.

CM Health is committed to working together with Mana Whenua i Taamaki Makaurau in consideration of the key strategic shifts required to deliver value for the population we serve.

Mana Whenua i Taamaki Makaurau represent the collective interests of a number of Iwi and Hapuu, including: Te Aakitai, Ngaati Te Ata, Ngaati Tamaoho, Ngaai Tai ki Taamaki, Ngaati Paoa, Te Kawerau a Maki, Ngaati Naho, Ngaati Tiipa, Ngaati Amaru, Ngaati Karewa / Tahinga. Counties Manukau District Health Board has established a Memorandum of Understanding with the Mana Whenua i Taamaki Makaurau Board that outlines the DHB's strategic intent and commitment to improve Maaori Health outcomes in the Counties Manukau district.

Counties Manukau DHB has adopted a principles based approach to recognising the contribution that the Te Tiriti o Waitangi can make to better health outcomes for all, inclusive of Maaori.

The articles of Te Tiriti and the principles of partnership, protection and participation implicitly recognise the important role the health sector plays in recognising the indigenous rights of Maaori and therefore the status and rights of Maaori to achieve equitable health outcomes in comparison to the rest of the population.

Please see Section 2.5.1 for detail of planned activities from 2021/22 that demonstrate how CM Health is committed to meeting the engagement and obligations as a Treaty Partner.

Clinical participation

Counties Manukau Health is committed to the national, regional and local strategies that guide the direction and delivery of care in New Zealand. Clinical and management leaders from within CM Health are active participants in national and regional forums focussed on meeting the health needs of New Zealanders as well as its local population. In 2019, senior clinical leadership was increased to better support improvements in delivering health outcomes, quality and safety of care and supporting the DHB's strategic direction. Service planning is undertaken in a partnership approach between managers and clinical staff, inclusive of development of this Annual Plan, and a Clinical Services Plan in 2021. CM Health clinical activities are overseen by the Clinical Governance Group, a team of senior clinical leaders. CM Health policy also requires Annual Plans to be endorsed by the Executive Leadership Team, for which membership includes the Chief Medical Officer, Chief Medical Advisor Primary Care, Chief of Allied Health, Scientific and Technical, Chief Nurse and Chief Midwife.

1.2 Message from the Chief Executive Officer of Counties Manukau Health

COVID-19 will continue to dominate our response and prevention efforts this year. In partnership with the Northern region we must maintain border controls to stamp out COVID-19 through health provision in managed isolation and quarantine facilities, and achieve high coverage of COVID-19 vaccination for our populations while also maintaining a surge capacity to deal with outbreaks as they occur.

We enter the new year having started community roll-out of COVID-19 vaccination with the establishment of two super vaccination sites, five local vaccination sites and many more GP and pharmacies accredited to vaccinate most of our population within the first 6-9 months of the year. We will have a low tolerance for inequities in access – we know too well the consequences of COVID-19 for vulnerable people. But, outside of the COVID-19 response, we are still busy with our day to day work in caring for our community.

Acute demand growth has seen Middlemore Hospital at continued high occupancy across medicine and surgery throughout 2020/21. To address this demand, we are investing in much needed winter and Emergency Department capacity in the 2021/22 year, funding an additional 41 beds this winter.

The coming year is one of transition as we prepare for the health system reforms and the dis-establishment of current governance structures. At the time of writing this Plan the replacement leadership arrangements are not known to us. However, all those who work in frontline healthcare and those who support those services in non-clinical roles should not be concerned about future employment. It is likely that most of our current delivery will be required. We should be hopeful, however, that decision making in our system will be streamlined and equity focused.

Mana Whenua has been co-opted to our Board as part of a work programme to strengthen our Partnership relationship. Mana Whenua will also work with us to support Maaori health capacity and capability in the Counties Manukau District. We will work with community partners to ensure that we are positioning our district well for the move into the new system. This includes supporting Pacific community and health leadership to work together to shape commissioning and the formation of a locality or community of interest. There are several areas we will be focusing on, including supporting locality and provider development across the district, building on the legacy of COVID-19 in creating innovation and looking at the opportunities for hospital and specialist services to approach regional working.

Our capital plan for the year is large – we expect to complete construction of the Cardiac Cath Lab, dialysis beds, additional ward capacity at Middlemore, open a Gastroenterology procedural suite, begin construction on the Manukau site and complete expansion in Community Hubs to accommodate more clinic spaces. This is much needed investment to not only provide more capacity but take care into communities.

Our most important objective this year as an employer of more than 9,000 people, however, will be to look after our staff and our wider health professional community. Wellbeing, pastoral care and support is crucial now more than ever as we face another challenging year.

I look forward to continuing to work with our Board, Mana Whenua i Taamaki Makaurau, our staff, local providers, communities and all those who regard themselves as part of the Counties Manukau Health whaanau during 2021/22.

Fepulea'i Margie Apa
Chief Executive

1.3 Message from the Chair of Counties Manukau Health, Chair of Mana Whenua i Taamaki Makaurau and Kai Whakahaere of Mana Whenua i Taamaki Makaurau

The past year has been a very busy and challenging year for us, balancing our need to meet growing acute demand whilst also managing the COVID-19 response and beginning the rollout of the vaccination programme. However, the COVID-19 response has also given us an opportunity to be innovative in our approaches to delivering healthcare for, and with, our communities. This has included partnering closely with our Maaori and Pacific communities and healthcare providers to ensure that we were understanding their perspectives and serving their unique needs throughout the response.

Our Te Tiriti partnership continued to develop during the 2020/21 year, with Mana Whenua representation now a feature on all of our Board and Board sub-committees, bringing a Treaty Partnership perspective to the governance of the Health Board which we see as essential in understanding our Whaanau Maaori and communities in serving their unique healthcare needs. With the coming changes to the health sector, Mana Whenua i Tamaaki Makaurau will be a leading voice for the community and district; partnership during the transition will be important in ensuring we represent the district and its healthcare needs accurately for the future. We will also be engaging with Pacific communities to form structures which ensure that their voices are likewise represented during the transition, in the forming of locality networks and in the new health system.

CM Health's strategic goal has for many years been to achieve health equity, and this is a focus of the health system changes. Maaori and Pacific populations continue to experience worse health outcomes in a number of measures and have a lower life expectancy than other groups. We see the role of the healthcare system as extending life expectancy and closing those gaps. We are currently redeveloping our equity plan to include definitive, measurable goals to help us achieve this and sit alongside the work we are already doing to achieve health equity.

Financial sustainability is an important element in ensuring we can continue to meet the needs of the communities we serve. In our previous annual plans, we had anticipated moving towards breakeven in the 2021/22 financial year; however, the realities of the 2020/21 year have made this position difficult to achieve without affecting our ability to address increasing clinical demand and manage risk. This is largely attributable to increasing acute demand and a disrupted two years in relation to our savings programme whilst responding to several incidents and epidemic events. Another crucial element making progress towards a financial breakeven position difficult is the fact that our population remains undercounted for the purposes of the population based funding formula, impacting our revenue. We were pleased to see a partial remediation of this position in the 2021/22 funding envelope, however the difference between the people we actually serve and those counted is 7,000 people, or $19.9m. It is important that the issue of underfunding is resolved if we are to achieve financial sustainability and meet the needs of the communities we serve. Within our baseline, the cost of responding to 'excess' numbers of diabetics equate to an estimated $39m of cost that other DHBs do not carry at the same scale.

Key to achieving our goals of continuing to meet growing demand and delivering on health equity is continuing to advance our significant capital programme through our 'Grow Middlemore', 'Grow Manukau' and 'Grow Community Hubs' portfolios of work over the coming year, and making sure that these developments have our population's needs at the core of their design.

We look forward to continuing to work together on our shared goals

From left to right:

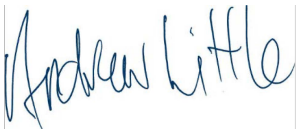
Barry Bublitz – Kai Whakahaere, Mana Whenua i Tamaaki Makaurau

Vui Mark Gosche – Chair, Counties Manukau District Health Board

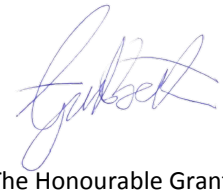
Robert Clark – Chair, Mana Whenua i Tamaaki Makaurau

1.4 Signatories

Agreement for the Counties Manukau Health 2021/22 Annual Plan between



The Honourable Andrew Little
Minister of Health
17 November 2021



The Honourable Grant Robertson
Minister of Finance
17 November 2021

Vui Mark Gosche
Chair
Counties Manukau District Health Board

Tipa Mahuta
Deputy Chair
Counties Manukau District Health Board

Fepulea'i Margie Apa
Chief Executive
Counties Manukau District Health Board

2. Delivering on priorities

This section describes the actions that CM Health will undertake to deliver on the Government's priorities in the 2021/22 year. This plan uses the code **'EOA'** to identify equitable outcomes actions specifically designed to reduce health equity gaps for Maaori and Pacific populations. This Plan will also reflect the Metro Auckland 2021/22 System Level Measures Improvement Plan.

2.1 Minister of Health's Planning Priorities

The following sections identify CM Health's key response actions to deliver improved performance against the Government's 2021/22 Planning Priorities and focus on our commitments to the Minister's Letter of Expectations. A number of these actions are specifically targeted to accelerate health gain and to reduce inequities for Maaori, Pacific and more deprived populations. The focus for the 2021/22 Annual Plan is on COVID-19 recovery and learnings, equity and a shift away from business as usual.

The 2021/22 Planning Priorities are:

- Achieving health equity and wellbeing for Maaori through Whakamaua Maaori Health Action Plan 2020-2025
- Sustainability
- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population health outcomes supported by a strong and equitable public health and disability system
- Better population health outcomes supported by primary health care
- Strong fiscal management.

These priorities support the Government's overall priority of Improving the well-being of New Zealanders and their families through:

- support healthier, safer and more connected communities
- make New Zealand the best place in the world to be a child
- ensure everyone who is able to, is earning, learning, caring or volunteering

Several of the priority areas benefit from or are directly influenced by the connections CM Health shares across the Northern Region. CM Health will work closely with regional partners to progress actions in a collaborative and consistent manner, rather than independently by each DHB.

2.2 Maaori health improvement in DHB Annual Plans

DHB obligations as a Treaty partner are specified in legislation. DHBs are to specify in their annual plans processes they use to meet these obligations. This includes, but is not limited to, information on:

- meeting the DHBs obligation to establish and maintain processes that enable Maaori to participate in, and contribute to, strategies for Maaori health improvement
- how the DHB will continue to foster the development of Maaori capacity for participating in the health and disability sector and for providing for the needs of Maaori
- how the DHB is giving effect to He Korowai Oranga and Whakamaua Maaori Health Action Plan 2020-2025

Please see Section 2.5.1 for detail of planned activities for 2021/22 that demonstrate how CM Health is planning to deliver on He Korowai Oranga and Whakamaua Maaori Health Action Plan and continue to action our obligations as a Treaty Partner.

2.3 Health equity in DHB Annual Plans

The Healthy Together Outcomes Framework describes the key outcomes and contributory measures that CM Health will need to monitor and target to achieve the strategic health equity goal, as well as the key inputs and outputs required. The Framework identifies two long-term outcomes to monitor our progress: quantity of life in terms of mortality measured by 'life expectancy at birth' and quality of life. Please refer to the 2019 – 2023 Statement of Intent for further information and a detailed description of the Framework.

On a quarterly basis, CM Health monitors progress against universal performance targets and its Statement of Performance Expectations (SPE) by ethnicity, to track progress toward achieving equity across performance measures and identify areas of focus for improvement and future planning.

CM Health recognises and respects Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. Te Tiriti o Waitangi establishes obligations for Maaori development, health and wellbeing by guaranteeing Maaori a leading role in health sector decision making in a national, regional, and whaanau/individual context. The New Zealand Public Health and Disability Act 2000 establishes requirements of DHBs with respect to Crown treaty obligations. This furthers commitment to Maaori health gain by requiring DHBs to establish and maintain responsiveness to Maaori while developing, planning, managing and investing in services that do and could have a beneficial impact on Maaori communities.

Te Tiriti o Waitangi provides four domains under which Maaori health priorities for CM Health can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Maaori.

Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the CM Health's provision of structures and systems that are necessary to facilitate Maaori health gain and reduce inequities. It provides for active partnerships with mana whenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Maaori leadership, engagement, and participation in relation to CM Health's activities.

Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

Article 4 – Te Ritenga (right to beliefs and values) guarantees Maaori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, CM Health as a Te Tiriti obligation to honour the beliefs, values and aspirations of Maaori patients, staff and communities across all activities.

Te Tiriti provides an imperative for Crown entities to protect and promote the health of Maaori, respond to Maaori health aspirations and meet Maaori health need. It is recognised that there is an interrelationship between the DHBs Tiriti obligations and responsibility to achieve health equity for Maaori, it also acknowledged that these are distinct obligations (and separate requirements in the NZ Public Health and Disability Act). Maaori health equity is often seen as the area of commonality and overlap between these two priorities. In practice this means, that any equity plans developed by the DHB will need to incorporate the specific right of Maaori to health equity and clearly affirm efforts to advance Maaori health as per our other accountabilities under te Tiriti.

Our priority groups for equity are local Maaori and Pacific communities. Asian communities represent over a quarter of the local population and also require consideration where health disparities exist.

In Counties Manukau, Pacific and Asian communities constitute significant proportions of the non-Maaori group. This means if the total non-Maaori group are used as a comparator to consider Maaori inequities, the inequities of the Pacific population can obscure the extent of the inequities for the Maaori population. On the other hand, the healthy migrant effect for some of the local Asian communities can also compound equity comparisons.

Where possible, data for CM Health will therefore be presented as four ethnic groups for annual planning and reporting purposes – Maaori, Pacific, Asian, and NZ European/Other (non-Maaori, non-Pacific, non-Asian). Further disaggregation will take place at service planning level where appropriate.

2.4 Responding to the Guidance

The priority actions described in this document reflect the Ministry of Health's guidance and instructions for DHBs. The actions identified in CM Health's 2021/22 Annual Plan have been developed in consultation with key stakeholders across the organisation, including PHO partners. In 2021/22 the focus for the actions to be included by the DHBs are on COVID-19 recovery/learnings and equity, and a move away from business as usual. Included in this section are the most important one or two key actions, that will have the most significant impact for the population.

Public Health plans

Auckland Regional Public Health Service (ARPHS) is the regional provider of public health services and services the Counties Manukau District and the Metro Auckland region DHBs. ARPHS is one of New Zealand's 12 public health units (PHUs). ARPHS provides public health services through health protection and promotion, and disease prevention. ARPHS and DHB staff works closely together to improve population outcomes for the people of Taamaki Makaurau. A key role for ARPHS is provision of regulatory public health services.

ARPHS' vision is Te Ora ō Taamaki Makaurau. ARPHS' strategic long term outcomes are:

- People are protected from the harm of notifiable infectious diseases.
- People are protected from the impact of environmental hazards.
- People live free from the harms associated with harmful commodities.
- The environments in which people live, learn, work and play promote health and wellbeing.

ARPHS' work includes management of notifiable infectious and environmental diseases, including operational management of the regional tuberculosis control programme. ARPHS provides advice and support on actual/potential environmental hazards such as drinking and recreational water quality, air quality, border health protection, and hazardous substances. Much of ARPHS' work involves working with other agencies, including work on liquor licensing, smokefree, emergency response, physical activity and nutrition and obesity prevention activities. These other agencies include central government agencies, Auckland Council, non-government organisations and workplaces. ARPHS is also responsible for refugee health screening undertaken at the Maangere Refugee Resettlement Centre.

Key points of intersection for ARPHS with DHB activities are interfaces with primary and secondary services in managing communicable disease outbreaks, policy engagement and submissions and improving physical and social environments to support reduced harm from tobacco, alcohol and unhealthy food.

ARPHS is a contracted service to CM Health reporting through ADHB and contributing to services for the CM Health population. The services are described in the ADHB Plan and referenced in the relevant sections of this plan.

Regional Service Planning

Northern Region Planning

2021/22 is the third year of implementation of the Northern Region Long Term Investment Plan for the period 2018-2037.

The investment plan sets out agreed changes in models of care and the planning and commissioning of services in the region, together with the capital, workforce, and information technology to deliver our future vision for the health system. Our strategy addresses the 3 key strategic challenges faced by the Northern Region:

1. Health status is variable; there are significant inequities for some population groups and geographic areas, as well as a large burden of ill health, which need a rebalancing of investment into prevention and early intervention.
2. Health services are not sufficiently centred around the patient and whaanau; in certain areas the quality, safety and outcomes of care are not optimal which require proactive networked care, centralising where beneficial for quality and localising where beneficial for access, in co-designed services which enable choice and control for whanau.
3. The needs of a rapidly growing, ageing, changing population are not clinically or financially sustainable with current capacity and models of care; new approaches are needed to moderate the demand for hospital care and enhance productivity and efficiency of services.

The DHB annual plan, together with the agreed regional work programme, aims to deliver on the commitments set out in our DHB and Northern Region strategies, including its fundamental Te Tiriti commitments.

In line with national guidance with no mandatory Ministry requirements for a Regional Services Plan in 2021/22 the strategy remains as an extension of the 2020/21 Regional Service Plan. The regional work programme for 2021/22 builds on the key themes that we have delivered or initiated in 2020/21 including:

- Delivering and implementing transformational changes to models of care for vulnerable services to achieve resilience, quality and equity
- Transforming diagnostics through regional pathology and imaging programmes,
- Continuing an equity led recovery from COVID-19 against planned care wait times and improving regional collaboration in managing capacity
- Continuing to strengthen regional emergency preparedness & response
- Further progressing an extensive workforce modernisation programme
- Rapid developments in IT systems to support COVID-19 and to leverage broader change
- The continued improvements in care through regional clinical networks supporting Cancer, Cardiac Care, Stroke, Trauma, Hepatitis C Elimination, and Mental Health & Addiction, Child Health and Child Development Services.

In the coming year we aim to strengthen the regional work programme by:

- Expanded Maaori and Pacific health gain programmes, contributing to equity
- Developing the next level of detail in the longer term clinical service, capital and technology plans

DHB planning commitments in 2021/22 include:

- Developing a longer term capital road map (2025-2037) in partnership with the Ministry of Health
- Combining the Long Term investment plan with sector-specific deep dives in primary and community services, public and population health, and with spatial clinical service planning to form a refreshed Long Term Health Plan
- Horizon two for the Information Systems Strategic Plan, moving from foundations to the underpinning technology to deliver transformational clinical service change
- Incorporating changes to ways of working within the region and in DHBs in line with the year one plans of the government's response to the Health and Disability Review.

All 2021/22 programmes of regional collaborative work align with national, and regional, strategic directions. This regional work will continue to be delivered through well-established mechanisms functioning under regional oversight

and regional governance groups with the continuing leadership and engagement of the Chairs, Chief Executives and Chief Medical Officers of all four DHBs.

2.5 Government planning priorities

The following sections identify CM Health's key response actions to deliver improved performance against the Government's 2021/22 Planning Priorities.

The 2021/22 Planning Priorities are:

- Achieving health equity and wellbeing for Maaori through Whakamaua Maaori Health Action Plan 2020-2025
- Improving sustainability
- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention
- Better population health outcomes supported by a strong and equitable public health and disability system
- Better population health outcomes supported by primary health care
- Strong fiscal management.

2.5.1 Give practical effect to Whakamaua: Maaori Health Action Plan 2020-2025

Whakamaua: the Maaori Health Action Plan 2020-2025 has been developed to achieve the vision of pae ora- healthy futures set out in He Korowai Oranga, the Maaori Health Strategy.

Importantly, the health and disability system is being challenged to do better and to go further. That includes continuing to meet our responsibilities under Te Tiriti o Waitangi (the Treaty of Waitangi), to address substantial health inequities, and to ensure all services for Maaori are appropriate and safe.

These challenges are substantial and require a strong plan to implement actions and meet expectations. The first part of this section, Engagement and obligations as a Treaty partner, is based on your current legislative responsibilities. The other sections are based on the objectives from Whakamaua. Some action areas from Whakamaua are highlighted in each part. These are specific areas for DHB attention in 2021/22.

Engagement and obligations as a Treaty partner		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Maaori and other groups **Government priority outcome:** Make New Zealand the best place in the world to be a child The DHB works with Mana Whenua i Taamaki Makaurau to implement the Hauora Plan and other tribal health plans including Waikato-Tainui's plan "Te Ara Whakatupuranga 2050". The Memorandum of Understanding between Mana Whenua i Taamaki Makaurau and the DHB will be reviewed after more than 20 years of its establishment.		
DHB activity	**Milestone**	**Measure**
Whakamaua Action 1.1: Developing Iwi partnerships to support local-level Maaori development and kaupapa Maaori service solutions 1. Work with Mana Whenua i Taamaki Makaurau to identify partnering opportunities that focus on equity for Maaori and achieving mutual health outcomes that are specific to following key strategic areas: • Health and Disability System Review • Co-commissioning design, planning and implementation with Iwi/Maori	Q1	Completion of a 5 Year Equity Strategy that outlines a 'living' outcome map and strategic plan which focuses on evidence- and experience-based priorities, protective factors and signs of wellbeing.
Whakamaua Action 2.3: Design and deliver professional development and training opportunities for Maaori DHB board members and members of DHB/iwi/Maaori partnership boards. 2. Provision of bespoke training programmes designed to meet the ongoing professional needs of Maaori/Iwi Board members	Q1	Q1 – Design and deliver training to Māori DHB Board members to improve their understanding of the system and to identify where opportunities exist. We are committed to creating a proactive and accountable system where Māori health equity is at the core of everything we do. Q2: Host training sessions for the Board, topics will include (by quarter): Treaty of Waitangi, racism and bias within the health system, Māori health inequities, and Mātauranga Māori – on-going Q4: Support two Māori DHB Board members to take up formal governance training opportunities

Whakamaua: Maaori Health Action Plan 2020-2025		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Maaori and other groups **Government priority outcome:** Make New Zealand the best place in the world to be a child		
DHB activity	**Milestone**	**Measure**
This section includes actions for the upcoming year that CM Health considers to be the most important for Whakamaua: Maaori Health Action Plan 2020-2025.		
Whakamaua Objective: Accelerate and spread the delivery of kaupapa Maaori and whaanau-centred services		
Whakamaua Action 3.1 – expand existing Maaori health workforce initiatives aimed at encouraging Maaori to enter health careers, including supporting existing initiatives such as Kia Ora Hauora in our local area. 1. Implementation of CM Health Workforce Plan 2. Provision of Hauora Maaori Training Programme	Q4	Assess status of current CM workforce needs and associate plans. Build and consolidate relationships with external organisations (e.g. Kia Ora Hauora) and pathways to strengthen kaimahi Māori workforce talent pipeline(s). Renew and extend existing Hauora Maori Training Programmes.
Whakamaua Action 4.4 – Increase access to and choice of kaupapa Maaori primary mental health and addiction services.	Q4	Commissioning model and outcomes programme for Kaupapa Maaori primary mental health and addiction services complete for implementation.
Whakamaua Action 6.1 – Adopt innovative technologies and increase access to telehealth services that streamline patient pathways and provide continuity of care for Maaori individuals and their whaanau 3. Design, development and implementation of Maaori Service Continuity and IT strategy with Iwi/Maaori building on recent experience of operating differently during COVID-19 alert levels 3 and 4	Q4	Maaori Service Continuity and IT 5-year strategy plan completed with resource requirements confirmed. Q4. Partner with a Māori health provider/s to pilot a community-based telehealth pod to reduce telehealth barriers to access for Māori and improve uptake.
Whakamaua Objective: Shift cultural and social norms		
Whakamaua Action 3.3 – Support DHBs and the Maaori health sector to attract, retain, develop and utilise their Maaori health workforce effectively, including in leadership and management, such as actions to implement the Tumu Whakaere/DHB CEO agreement on workforce and any other local actions	Q4	Maaori health workforce 5 year strategy and action plan complete with resource requirements confirmed.
Whakamaua Objective: Reduce health inequities and health loss for Maaori		
Whakamaua Action 4.7 – Invest in innovative tobacco control, immunisation and screening programmes to increase equitable access and outcomes for Maaori 4. Increased Maaori-led, Maaori-focused innovative approaches that contribute to improving equitable immunisation coverage for Maaori.	Q1	Develop an integrated immunisation plan that builds on current community programme activity designed to improve equitable immunisation coverage for whaanau Maaori.

Whakamaua: Maaori Health Action Plan 2020-2025		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Maaori and other groups **Government priority outcome:** Make New Zealand the best place in the world to be a child		
DHB activity	**Milestone**	**Measure**
This section includes actions for the upcoming year that CM Health considers to be the most important for Whakamaua: Maaori Health Action Plan 2020-2025.		
		Invest and implement in a new integrated approach. Align with equity living outcomes framework
Whakamaua Action 8.2 – Actions undertaken to publish our plans and progress in achieving equitable health outcomes for Maaori, including communication plans 5. Development of Maaori Communication Strategy and Plan.	Q4	
Whakamaua Objective: Strengthen system accountability settings		
Whakamaua Action 1.4 – Engage with local Iwi, using the engagement framework and guidelines, when developing major capital business cases**.** 6. Agreed engagement framework and guidelines set out in MOU between CM Health and Mana Whenua I Tamaki Makaurau	Q1	Agreed framework broadened to include flexible partnerships that aligned to Treaty responsiveness and advance Maaori health gain across the region.
Whakamaua Action 8.5 – Ensure that major system funding frameworks consider and adjust for unmet need and the equitable distribution of resources to Maaori. 7. Develop a commissioning strategy for the DHB that is aligned with and delivers against Te Tiriti o Waitangi responsibilities and will support achievement of equitable Maaori health outcomes.	Q4	Strategic alignment with an equity living outcomes framework to be completed and evidence-based.
Whakamaua Action 4.9 – Invest in growing the capacity of iwi and the Maaori health sector as a connected network of providers to deliver whaanau-centred and kaupapa Maaori services to provide holistic, locally-led, integrated care and disability support 8. Co-commissioning design, planning and implementation with Iwi/Maaori	Q1	Q1. Ensuring all Māori health providers have integrated contract rollover processes to allow for identification of opportunities for holistic models of care Q2. Commissioning models and outcomes programme for delivery of whanau centred and kaupapa Maaori services complete for implementation Q4. Work with Māori health providers to reorient services to be better aligned with the needs in their community Q4. Implement a sustainability process with Māori health providers

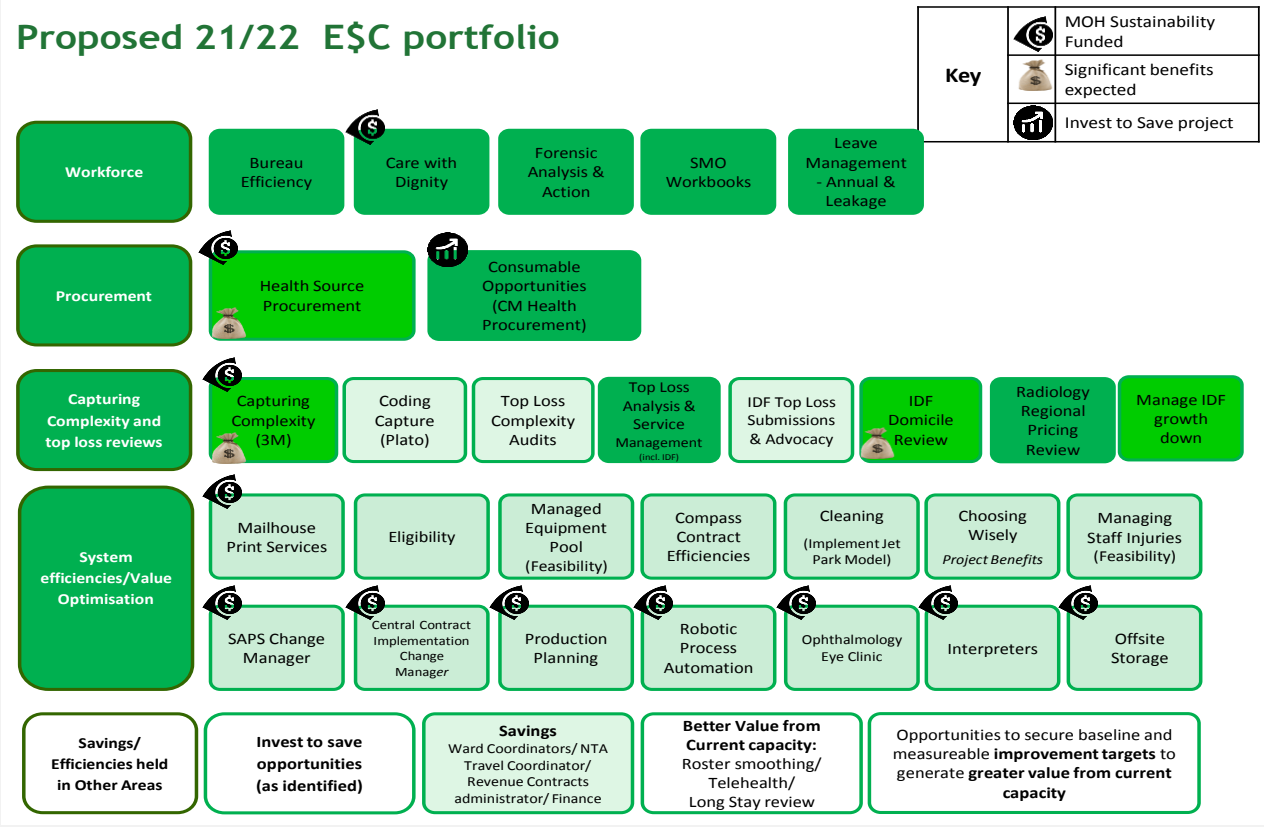
Whakamaua: Maaori Health Action Plan 2020-2025		
Government theme: Improving the wellbeing of New Zealanders and their families **System outcome:** We have health equity for Maaori and other groups **Government priority outcome:** Make New Zealand the best place in the world to be a child		
DHB activity	**Milestone**	**Measure**
This section includes actions for the upcoming year that CM Health considers to be the most important for Whakamaua: Maaori Health Action Plan 2020-2025.		
Whakamaua Action 5.6 – Please include the most significant one or two actions the DHB is undertaking to support the delivery of Whaaia te Ao Maarama 2018-2022: The Maaori Disability Action Plan	Q4	Q1. Review responsiveness of current model of care accessed by tangata whaikaha and their whaanau Q4. Co-designing of new or enhanced service delivery Q4. Refining data being recorded and reported by disability services for equity

2.5.2 Improving sustainability

As New Zealand's population has continued to grow and age, with more complex health needs, the system has worked hard to keep up with demand, however the financial performance of DHBs is variable and has deteriorated in recent years. An enhanced focus on improving sustainability is required.

This plan demonstrates how strategic and service planning, both immediate and medium term, are supporting improvements in system sustainability, including work initiated from/supported by dedicated sustainability funding with the end goal of improving quality and capacity for patients.

Consideration of sustainability objectives and actions includes how CM Health will work collectively with our sector partners to deliver the Government's priorities and outcomes for the health and disability system while also contributing to a reduction in cost growth paths and deficit levels.

Short term focus 2021/22: Improvements to support improved sustainability in 2021/22		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Following significant effort over the last 6 years to deliver sustainable financial savings at CMH, it has become increasingly difficult to secure new and ongoing cost reduction opportunities each year. In addition, in 2020 and 2021, the urgency of the COVID-19 response has resulted in the need to redeploy staff to support DHB efforts and to prioritise this work over existing projects. As a result, 21/22 will see an increasing focus on optimisation and efficiency to extract maximum value from existing DHB capacity and any current and/or future investment and ensure best care for our patients. In order to deliver to CM Health's sustainability requirements; the Every $ Counts savings portfolio has been developed to support services to deliver system efficiencies and cost savings and to identify and deliver system wide savings, efficiencies and optimisation across the DHB. The E$C Portfolio is made up of four key work streams; Workforce, Procurement, Capturing complexity and Top Loss reviews, and System efficiencies and optimisation. The plan also aims to enable invest to save opportunities and better value from current capacity. MOH Sustainability funded projects are captured tracked and supported through the portfolio. A visual of the plan is attached below. Currently the total overall incremental savings plan for CM Health for 21/22 is $23.3M.  		
Sustainability funding initiatives		
A focus on clinical documentation and documentation management continues with an end goal of improving clinical quality, communication regarding care, revenue capture and decision making. This increased use of technology and data will enable a stronger patient focus and support better benchmarking and understanding of patient complexity and opportunities for improved patient care. In 2021/22 we will	Q1 Q2 Q3 and 4 Q1-4	Q1 – CDS employed and oriented Q2 – test CDs model across 2 surgical areas – general surgery and plastics Q3 and 4 – benefits realisation (incl. approx. $2m upside)

implement the Clinical Documentation specialist model in CM Health with the intention of improving documentation quality, complexity capture and where relevant IDF revenue. Additional strategies will include ongoing implementation of systems to phase out paper and create electronic capability, improved data collection and coding improvements.	Q1-4	Q1-4 – ongoing reduction of paper reliant communication Q1-4 – Coding Top Loss Complexity audits (incl. approx. $100k upside)
National Analytics		
Top Loss service improvements – Right care, right time, right place. In 2021/22 CM Health will utilise data insights and analysis to identify and explore opportunities where CM Health performance varies from the mean to determine if there are opportunities for our improvement; and then to partner with our clinicians to explore options for change ultimately leading to increased quality of care for our patients.	Q1 Q2 Q3 and 4 Q4	Q1 – establish areas of focus Q2 – data deep dive to determine opportunities Q3&4 – analysis and exploration with clinical change leaders Q4 – benefit realisation (incl. approx. $200k upside)
Strengthened production planning		
Ensuring patients receive care in a timely manner, and where possible, closer to home will be a focus derived from data driven production planning to more accurately meet our community's demand. This includes having a single joined up approach with clinical leaders of divisions to utilise models of care to allow all professions to work at the top of scope. It also includes robust outsourcing including price management and best utilisation of expertise across the region.	Q1-4 Q1-4	Review of models of care for most effective use of resources Review of IDF inflows and outflows (this initiative will increase capacity; however it will not result in direct financial savings)

Medium term focus (three years)		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Innovative approaches from COVID-19 learnings		
The DHB has to be agile to respond to COVID resurgences and the vaccination rollout to ensure the community's protection is paramount during the pandemic. The pandemic response requires timely access to accurate information for decision making. The DHB continues to build on its development of data analytic capability utilising the Qlik app and other technology to deliver timely and accurate data to enable agile decision making as required in priority timeframes.	Q1-4	Q1-4 – delivery of Qlik apps Q1-4 – embedding of training and support for DHB uptake (This project will enable better use of data to drive evidenced based decision making however will not enable direct financial savings)
Sustainable system improvements over three years		
The capital investment programme for CM Health in 2021/22 is substantial, with an emphasis on addressing growth and demand on services. Capital investment will expand, improve and provide more efficient care to all patients. In 2021/22 CM Health will invest further support into the area of procurement and financial expertise to develop capability to support management of cost growth in the medium term and deliver quality business cases to the MoH for approval. Savings and cost containment are being sought both in partnership with HealthSource, Pharmac and other central agencies and internally within the DHB. Regional partnerships are also being	Q1 Q1 Q2 Q2-4	Q1 – development of governance structure and procurement strategy to support project delivery Q1 - Endorse regionally agreed financial disclosures, modelling and assumptions for business cases Q1 – employment of 2 procurement specialist positions

Medium term focus (three years)		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
developed. The addition of 2 positions under the sustainability funding will help support CM Health to identify further opportunities to make savings and to maximise the uptake of potential benefits. CM Health is also involved in and supporting the implementation of FPIM and the health system catalogue implementation planned for late 2021.		Q1 – employment of 1 finance business partner – capital projects Q2 – identification of procurement opportunities Q2-4 – set up of discrete project working groups focused around savings and change initiatives (incl of approx. $1.5m upside from the procurement initiatives)
Quantified actions from the DHB's path to breakeven		
In 2021/22 CM Health will continue to work across various strategies to optimise utilisation of our largest asset, the workforce. CM Health will focus on strategies to increase roster efficiencies, reduce external bureau use, overtime, vacancies and reduce annual leave liability by using data analytics and technology to support planning and timely decision making enabling best use of the workforce.	Q1 Q2 Q2 Q3 Q3 Q3/4	Q1 – Bureau efficiency support including bureau sizing, and overtime review Q2 – care with dignity expansion Q2 – bespoke Bureau efficiency projects Q3 – vacancy review and strategy Q3 – real time dashboard for Nursing managers Q3/4 – staggered rollout/ implementation Workforce dimensions (incl. approx. $1m upside)
Improving our management of IDF inflows and outflows will maximise clinical delivery and best value for the local population. Our additional goal is to improve costing models and accuracy of recording.	Q1-4 Q1-4	Q1-4 – ongoing domicile management Q1-4 – strategies to improve data capture and minimise error (incl. approx. $1.5m upside)
The specialist population health team continue to work with Statistics NZ and central agencies to identify challenges with our DHB funding around specialist groups including spinal cord injury funding, disability support service users, deprivation and others. This is critical as these patient groups are medically complex and often vulnerable. Corrections to funding are critical to the fairness allocation of resources to those communities in need.	Q1-4	Q1-4 – ongoing analysis as to challenges for CMH population groups. Q1-4 – analysis reports complete (Any financial benefits are dependent on response from central agencies.)

2.5.3 Improving child wellbeing

The Child and Youth Wellbeing Strategy (the Strategy) provides a framework to align the work of government and others to achieve the vision of 'Making New Zealand the best place in the world for children and young people'.

Counties Manukau Health will actively work to improve the health and wellbeing of infants, children, young people and their whaanau and carers with a particular focus on improving equity of outcomes.

Maternity Care		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Making New Zealand the best place in the world for children and young people		
DHB activity	**Milestone**	**Measure**
1. Analyse COVID-19 learning in Maternity Services and report key findings/actions that influence primary birthing outcomes.	Q1 Q4	Q1 Report and Project plan available Q4 report on implementation of actions.
2. Undertake project to increase primary birthing unit utilisation in CMDHB catchment area	Q1 Q4	Q1 Project plan developed with milestones to be reported Q4
3. Develop wrap around midwifery care models for vulnerable women particularly Maori women where family violence, trauma and mental health conditions adversely affect their maternal or child outcomes	Q1 Q3	Q1 Development of proposal and timeline for implementation Q3 Report on action
4. Implement sustainable midwifery workforce initiatives to address midwifery shortfall including safe staffing, on-going midwifery staff development, and value recognition.	Q2	Q2 Implementation of CCDM in Maternity Services Q4 Staff values model implemented
5. Implement PMMRC[6] recommendation to develop model of care that meets the needs of Indian women	Q1 - 4	Q1 Undertake review of outcomes of mother of Indian ethnicity and commence co-design of model of care. Q2-4 Report on actions implemented
6. Implement PMMRC recommendation to provide cultural competency training to all health professionals working in Maternity Services	Q1-4	Q1 Develop framework for cultural competency training Q2-4 Report on actions implemented
7. Develop a scoping of radiology capacity in Counties Manukau Health and options to increase timely access to pregnancy ultrasound scans	Q1-4	Q1-scoping paper completed Q2-4- Report on options and develop a plan of implementation
8. Develop an evaluation to inform the future direction of funded pregnancy and parenting education in Counties Manukau	Q1	Q2 Scope recommendations from the evaluation Q3-4 Implement recommendations
9. Improve the uptake of Survive and Thrive 2025 to support the integration of social services within midwifery and WCTO services	Q1 Q3	Scope and increase referral capabilities to Social Services via Survive and Thrive 2025 Report on baseline data of whaanau referred to social services via Survive and Thrive 2025
10. Implementation of the Best Start Pregnancy Tool which will function as a pregnancy register in primary care in order to support antenatal flu and pertussis vaccination. The Best Start Pregnancy Tool will be utilised to also support	Q4	50% of pregnant Maaori and Pacific women receive an influenza and a pertussis vaccine

[6] The Perinatal and Maternal Mortality Review Committee (PMMRC) is an independent committee that reviews the deaths of babies and mothers in New Zealand.

enrolment into primary care and as an opportunity to consolidate the immunisation key messages. (* Contributes to regional SLM plan – Improving Ambulatory Sensitive Hospitalisation in children (0-4 yrs old)		
11. Improve the oral health approach for preschool tamariki by redesigning the local model of care in order to reduce the number of carriers for Maaori and Pacific children.	Q1-4	• Scope project including stakeholder engagement • Design approach • Implement new service approach • Monitor and review

Immunisation		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Making New Zealand the best place in the world for children and young people		
DHB activity	**Milestone**	**Measure**
1. Implement the COVID-19 Vaccination and Immunisation Programme across the community, ensuring it is taken up by Maaori and Pacific people at equal or higher rates than other populations. - Develop and implement an integrated immunisation approach at Maaori-led COVID-19 vaccination centres to support equitable access to immunisations for whaanau	Ongoing	Vaccination centres in place
2. Develop an immunisation engagement and communications plan that is focused on delivering key, consistent and culturally appropriate messages to help promote immunisations and increase education around the importance of immunisation. - Incorporation of integrated information and messages to ensure Maaori whaanau are in receipt of coordinated information to support informed decisions about a range of immunisations	Q1	Plan implementation initiated
3. Provide longer-term, ongoing support and training to build the Maaori workforce to undertake vaccinations	Q4	Training and support provided across Maaori providers
4. Improve maternal immunisations approach with focus on LMCs/midwives (including early engagement with parents to discuss the benefits and dispel concerns around immunisation, prior to the arrival of the baby.) (* Contributes to regional SLM plan – Improving Ambulatory Sensitive Hospitalisation in children (0-4 yrs old)		Q1 Scope project including stakeholder engagement Q2 Co-design with LMCs and service users Q3 Implement improved service approach Q4 Monitor and evaluate
5. Prototype new Outreach Immunisation Service approaches in Counties Manukau for 0-5 year olds including developing a new prioritisation matrix. The new OIS service will actively work with other agencies to share whole of system data, including the latest contact details of a child in order to improve the reach and efficiency of the outreach service. (* Contributes to regional SLM plan – Improving Ambulatory Sensitive Hospitalisation in children (0-4 yrs old)	Q1-2 Q3-4	• Establish a new service delivered by the DHB • Monitor and review the service

Immunisation		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Making New Zealand the best place in the world for children and young people		
DHB activity	**Milestone**	**Measure**
6. Primary care and WCTO providers to work collaboratively to support children who will soon be turning two years of age to access immunisation services (in primary care or via an OIS service or immunisation by WCTO provider).	Q2	• Agree a process for identification of children and information sharing arrangements by Q2

Youth health and wellbeing		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Making New Zealand the best place in the world for children and young people		
DHB activity	**Milestone**	**Measure**
1. **Priority Youth Populations** a. Prioritise Maaori and Pacific rangatahi for comprehensive bio-psycho-social assessment in SBHS, AE, and TPU **(EOA)** b. Upskilling school based health workers by providing education on diversity, cultural safety, and disability	Q2 Q4	95% of Y9 Maaori and Pacific rangatahi receive bio-psycho-social assessment in SBHS, AE, and TPU in 2021. 90% of SBHS nursing workforce receive training in diversity, cultural safety, and disability by 31 Jan 2022
2. **SBHS Quality Improvement** a. Nurses working to the top of their scope of practice: support nurses to become provisional vaccinators and prescribers in community health	Q4	50% increase in the number of CM health funded school nurses who become provisional vaccinators and registered nurse prescribers in community health
3. **Telehealth** a. Scope feasibility and seek resourcing to establish an approved secure telehealth platform to increase users' access to SBHS. Include engagement with Maaori and Pacific young people to ensure that platform works for Maaori and Pacific young people **(EOA)**	Q4	Feasibility study completed by 31 December 2021

Family violence and sexual violence		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Making New Zealand the best place in the world for children and young people		
DHB activity	**Milestone**	**Measure**
COVID-19 recovery		

Family violence and sexual violence		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Making New Zealand the best place in the world for children and young people		
DHB activity	**Milestone**	**Measure**
1. COVID-19 reduced our ability to deliver the MoH IPV programme and so education and training ceased and reduced staff awareness on how to safely manage incidents of IPV. In response to a significant increase in the number of family harm incidents attended by the Police in the Counties Manukau region, an education package has been developed specifically focussing on safety planning. The package has been created to support frontline staff in both the Emergency Department (ED) and maternity services. It focusses on areas of immediate safety in response to there being limited access to community services during COVID lockdown periods and the significance of victims being supported to action a safety plan to meet their unique needs. a. Complete the development of the package b. Roll-out as part of Annual Update Day for Midwives c. Deliver on the floor support in ED	Q1 Q1-Q4 Q1-Q4	Number of sessions and staff attendances Complete an audit of feedback forms from participants and adjust the sessions according to any emerging themes
Evidenced-based equity actions focused on Maaori and Pacific populations		
2. Pilot Project at Otara/MSD/ATWC/Health This project will involve a group of 8-10 families who are actively involved with Oranga Tamariki at the Family Group Conference (FGC) level of intervention. It is anticipated there are opportunities to reduce the risk factors associated with why the children have come under the review of Oranga Tamariki. There will be a collaboration with Anglican Trust for Women and Children (ATWC) where a Social Worker will be allocated to work alongside the family throughout their journey. The project will offer a Paediatric Health Assessment supported by a Paediatrician and Clinical Nurse Specialist (CNS) at a venue determined to best meet the needs of the whaanau. At FGC, a member of the health team will be present to discuss health findings with the whaanau to ensure the outcomes are agreed as part of the FGC plan. The ATWC Social Worker and CNS will remain in support of the family until they are formally discharged from Oranga Tamariki. **(EOA)** a. Set up clinic process and venue b. Participate in FGCs c. Present health outcomes and information to wider whaanau at FGC	Q1-Q2 Q1-Q4 Q1-Q4	Completion of all assessments Participation in FGC Self-audit on outcomes Review whanau engagement and access to recommended services

2.5.4 Improving mental wellbeing

Together we must continue to build a whole-of-system, integrated approach to mental health, addiction and wellbeing that provides holistic options for New Zealanders across the full continuum of need.

People with lived experience of accessing mental health or addiction services and their families must be central to this.

Counties Manukau Health will embed a focus on wellbeing and equity at all points of the system, while continuing to increase focus on mental health promotion, prevention, identification and early intervention.

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction and the Government's response have set the direction for transforming New Zealand's approach to mental health and addiction. This transformation has become more critical in the wake of COVID-19 and the expected ongoing impacts on people's mental wellbeing.

Actions in this plan further this transformation and align with the mental wellbeing framework that underpins Kia Kaha, Kia Maaia, Kia Ora Aotearoa: COVID 19 Psychosocial and Mental Wellbeing Plan.

Collective action is needed to build a whole-of-system, integrated approach to mental health, addiction and wellbeing that provides holistic options for New Zealanders across the full continuum of need.

Improving mental wellbeing

Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Supporting the psychosocial response to and recovery from COVID-19 for the local population		
1. Continue to build on and contribute to cross-agency planning led by the Social Wellbeing Board to address the social, cultural and economic impact of COVID-19. Specifically agree on a psycho-social response to build resilience in the community a. Establish a joint response with Manurewa and Papakura maraes to build place-based resilience b. Extend joint response to Papatoetoe community c. Extend joint response to Pasifika in Otahuhu and Mangere	Q1 Q2 Q3	Q1. Localised Community Cross-agency COVID-19 Response Plan developed for Manurewa & Papakura maraes Q2. COVID-19 Response Plan developed for Papatoetoe Q3. COVID-19 Response Plan developed for Otahuhu and Mangere
2. Increase capability and capacity of system to manage increase of stress and distress associated with COVID-19 a. Ensure workforce mobility capability to provide mental health services (MH03)	Q2	Q2. Increase in audio visual tools commensurate with levels of lockdown
Integration of primary mental health and addiction services with specialist mental health and addiction services		
3. Develop clear pathways to support the national development of 'access and choice' initiatives such as general practice health improvement practitioners and health coaches. a. Develop referral and advice pathways for Health Improvement Practitioners(HIP) and Health Coaches (HC). b. Develop new referral and advice pathways for youth primary MH services c. Develop new referral and advice pathways for Maaori and Pasifika primary MH services	Q2 Q3 Q4	Q2. HIP and HC pathways complete Q3. Youth primary MH pathways complete Q4. Maaori and Pasifika primary MH pathways complete
Addressing inequitable mental health and addiction outcomes experienced by Maaori and Pacific		
4. Reduce rate of Maori on indefinite orders under the Mental Health Act a. Complete s.76 clinical reviews within regulatory timeframes b. Ensure service users coming off a CTO and receiving funded medication have ongoing NGO support	Q4 Q2	Q4. 90% s.76 clinical reviews completed on time Q2. Implement the funded medication pathway
5. Increase uptake of Kaupapa Maaori and Pacific cultural liaison services a. Q1 Audit DNA rates for Maaori and Pasifika MH&A service users b. Identify issues and propose recommendations	Q1 Q2	Q4. Implement Audit recommendations
Follow-up within seven days post-discharge from an inpatient mental health unit (MH07)		
6. Continue participation in the HQSC Connecting Care Project & implement the Generic Discharge Pathway across all MH&A teams a. Increase MH02 sample size to 10% of each MH&A service	Q1	95% clients with an open referral have a wellness plan 95% audited wellness plans are of acceptable standard
7. Improve accessibility and availability of MH07 reporting a. Develop MH07 report in Qliksense b. Include in Qliksense, Build 2.0	Q1 Q3	Q3. MH07 report available via Qliksense

2.5.5 Improving wellbeing through prevention

Preventing and reducing risk of ill health and promoting wellness is vital to improving the wellbeing of New Zealanders. As the population grows and ages, it is important to orient the health and disability system towards a public health and prevention focus. This focus includes working with other agencies to address key determinants of health, creating supportive health enhancing environments identifying and treating health concerns early and ensuring all people have the opportunity and support to live active and healthy lives.

PHUs have an important role to play to address key determinants of health, improve Maaori health and achieve health equity and wellbeing by supporting greater integration of public health action and effort. DHBs and their PHU both have a role in contributing to improving the health and wellbeing of the population through prevention.

Auckland Regional Public Health Service (ARPHS, PHU for the metro Auckland region), provides public health services on behalf of CM Health. ARPHS is contracted and reports through ADHB and their contribution to services for the CM Health population for the Annual Plan is described in the ADHB Plan. This is referenced where appropriate in the sections below.

Communicable Diseases		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
ARPHS will be managing this on behalf of CM Health and the other metro Auckland DHBs and their contribution for this section is described below and will be reported through the ADHB Annual Plan.		
Support COVID-19 recovery/embed learnings ARPHS will be managing the health promotion and protection aspects of this on behalf of CM Health and the other metro Auckland DHBs and their contribution for this section is described in, and will be reported through, the ADHB Annual Plan 1. Maintain outbreak response capability for COVID-19 in the areas of prevention, preparedness and response, which is fundamental to New Zealand's public health response to the global COVID-19 pandemic	Ongoing	
Transition Pae Ora Maaori and Pacific response models, including mahaaki services, from the COVID-19 Response Unit to the wider Auckland Regional Public Health Service (ARPHS), which transfers learnings into ARPHS service delivery and deepens the cultural appropriateness of responses to communicable disease events **(EOA)**	Q4	
Core functions ARPHS maintains an appropriate and efficient system for receiving, considering and responding to: • notifications of suspected and confirmed cases of communicable disease • public health management of cases of communicable disease and their contacts • enquiries from medical practitioners, the public and others about suspected communicable disease of public health concern These actions help to ensure that the population of Taamaki Makaurau is protected from notifiable infectious diseases	As required	

Environmental Sustainability		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Support COVID-19 recovery/embed learnings		
Update the CMDHB Travel Plan for staff and public to reduce travel-related carbon and to encourage methods of active transportation. (COVID-19 response required opportunities for alternative working arrangements and the realisation that active transportation was taken up by more people when the roads less busy)		
1. Development of draft plan	Q1	Travel Plan implemented
2. Approved Travel Plan 2022-25	Q2	
3. Assess progress of travel plan initiatives	Q4	

Improve the integration that environmental sustainability has within the organisational strategy in order to work towards the carbon neutral 2025 goal. (Both the COVID-19 response and the Carbon Neutral Government Programme has highlighted a need to attend to climate change risks such as supplier insecurity and outbreaks)		
4. Approval for sustainability aims to be integrated into organisational strategy	Q1	Reduction in carbon footprint
5. SMART goals translated into KPIs for departmental responsibility	Q2	
6. Assessment of success of integration as measured by carbon footprint	Q4	
Evidence-based equity actions – Maaori		
Establish what the organisation can do for local iwi to meet the obligations of environmental kaitiakitanga		
7. Engage iwi and develop environmental kaitiakitanga plan for the Manukau Health Park build.	Q1	Development of environmental kaitiakitanga plan
Development of sustainable healing gardens at Manukau Health Park with engagement of Mana Whenua		
8. Inclusion of Mana Whenua at each stage of the building process	Q2	Development of environmental kaitiakitanga plan
9. Maintain inclusion of local iwi environmental plan as build progresses	Q4	
Evidence-based equity actions – Pacific		
Ensure that the Pacific community is well represented when presenting climate change risks on the CM Health risk register. Pacific people are disproportionately affected either by direct climate change migration or because of cultural heritage.		
10. Present Climate change risks to ELT and incorporate risks into CM Health register.	Q1	Inclusion of Pacific community climate change risks in the risk register
11. Review that the climate change risks are being acknowledged in planning & decision making.	Q2	
12. Assess risks in register & alter or add as required.	Q4	

Antimicrobial resistance		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
1. In 2021/22 CM Health will focus on those control methods identified by the World Health Organisation as the most important for control of antimicrobial resistance: antimicrobial stewardship, screening and environmental decontamination a. Increase compliance from clinical areas for screening as per requests or admission criteria. b. Consult on facilities development to increase ability to manage infectious diseases.	Q2 Ongoing with multidisciplinary team including engineering /ventilation issues	
2. CM Health Antimicrobial Stewardship Committee continues to meet monthly to discuss issues and strategies relating to antimicrobial usage, multidisciplinary representation.	Ongoing	

3. Continue and expand the CM Health internal surveillance processes for multidrug-resistant organisms (MDROs) in line with national Carbapenemase-producing Enterobacteriaceae (CPE) management guidelines. Activities include screening of patients who have spent time in overseas hospitals and patients who have recently travelled to certain countries a. Continue to improve responsiveness to new MROs of significance to control	Q1	
4. Establish an efficient MDRO screening system that is consistent with the New Zealand Antimicrobial Resistance Action Plan and local epidemiology (i.e. high immigrant population with relatively high rates of MRSA and CPE). Increase isolation capacity a. Get adequate compliance from clinical areas (especially ED) for screening as per requests or admission criteria. b. Refine screening protocols according to developing risk.	Ongoing	
5. Primary care and residential care settings will continue to work to ensure that front-line IP&C practices are implemented continuously, effectively and consistently and in alignment with the New Zealand Antimicrobial Resistance Action Plan and other relevant documents such as the "IPC and management of CPE" (Guidelines for HCP in NZ acute and RCF) Ministry of Health 2018 (see activity 4). a. Improved performance against infection control standards in the integrated ARC audits b. Aim to establish resource to provide dedicated primary care/ARC IPC support and education on such topics as sterilisation, Hand Hygiene, PPE and COVID	Q4	
6. CM Health Senior Infection Control Practitioner continues to provide support and advice to primary care (PHOs and general practices) on an ad-hoc basis and as requested (including COVID-19 advice)	As required	
7. CMH operates a restricted antibiotic policy of many classes. Audits of antimicrobial prescribing in hospitals to identify opportunities to improve appropriate prescribing a. Annual data collection to establish usage data. Presentation on data to areas targeted for improvement, as well as Antimicrobial Stewardship Committee	Ongoing	
8. Audit current intravenous (IV) to oral antibiotic SWITCH programme to reduce unnecessary exposure to invasive devices such as IV cannulae and reduce costs associated with IV antimicrobials. a. Conduct audit using established methodology. Presentation on results to Antimicrobial stewardship committee. Results to be communicated to individual services and the AMSC to inform continuous improvement	Q2	

9. Audit current usage of surgical antibiotic prophylaxis to ensure compliance with guidelines and reducing unnecessary patient harm from over use of broader spectrum antibiotics a. Audit surgical antibiotic prophylaxis using approved methodology. Presentation to Anaesthesia and Surgical Care.	Q2	
10. Develop and institute a process for establishing equity for funded vaccinations a. Use quality improvement methodology to improve access for inpatients who qualify for a funded vaccination.	Ongoing	
11. Work towards regional approach to antimicrobial stewardship – including hospital and community sectors. a. Current regionalisation includes: standardised empiric treatment guidelines for hospital and community sector, management of beta-lactam allergy, training and education provided to community practitioners	Q2	
12. Building on research on antimicrobial use and infections: looking at discrepancies in ethnic groups in the CMH area a. Completion of research b. Retrospective review of Staphylococcus aureus bacteraemia and cellulitis. c. Community antibiotic usage amongst different ethnicities.	Q2	

Drinking water		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
ARPHS will be managing this on behalf of CM Health and the other metro Auckland DHBs and their contribution for this section is described below and will be reported through the ADHB Annual Plan.		
Compliance and enforcement activities • Undertake interim compliance and enforcement activities relating to the Health Act 1956, while drinking water functions are transferred to Taumata Arowai, the new national drinking water regulator. This will ensure there are no gaps in enforcement during the transition to the new authority	As required	
• Transfer drinking water supplies data and regulatory function to Taumata Arowai	Q1 and ongoing until the transfer has occurred	
• Report against the performance measures contained in the Drinking Water planning and reporting template 2021/22 (Vital Few Report)	Q2, Q4	

• Highlight non-compliant supplies, or water supplies that predominantly serve Maaori or Pacific, or those which potentially pose public a health risk, to Taumata Arowai (EOA)	Q1 and ongoing	

Environmental and border health		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
ARPHS will be managing this on behalf of CM Health and the other metro Auckland DHBs and their contribution for this section is described below and will be reported through the ADHB Annual Plan		
1. Support COVID-19 recovery/embed learnings In the event of a suspected, probable or confirmed COVID-19 case on board of a ship in New Zealand waters, liaise with maritime stakeholders, NZ Customs, Ministry for Primary Industries, ship agents, Ports of Auckland/Harbour Control for the prevention of secondary spread of the infection into the community	Q1 and ongoing	
2. Manage extension of the Northern Region's vaccination programme to include priority groups (as indicated by the Ministry) within the general population through co-developed strategies with Māori and Pacific community partners, venue selection and communication activities **(EOA)**	Ongoing	
3. Evidence-based equity actions Partner with Ngaati Whaatua to identify common priority areas of environmental health activity and develop an equitable action plan to address concerns. This will include an agreed communications pathway, sharing of information and timely response to emerging issues (EOA)	Q2, Q4	
To ensure culturally appropriate community engagement with Pacific communities **(EOA):** a. Develop and implement a Pacific model for enteric disease investigation (DI) b. Deliver training to all DI staff on the new Pacific engagement model	Q2 Q4	
4. Compliance and enforcement activities Within the funding provided, undertake compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation, by delivering on the activities and reporting on the performance measures contained in the Environmental Health planning and reporting 2021/22 template, across the three Metro Auckland DHBs. This is important to minimise the risks of adverse health impacts and to enable communities living in Taamaki Makaurau to be free from environmental health hazards Activities include: • Work with Auckland Council to provide public health advice on strategic long-term planning regarding urban development while ensuring ARPHS focus is	Ongoing Q1 and ongoing	

Environmental and border health		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
aligned with mana whenua priorities within the ARPHS region • Provide Vital Few reports	Q2, Q4	

Healthy food and drink environments		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
1. DHB Healthy Food and Drink Policy Following the discussion at the national Chairs and CEs meeting in November 2020, CM Health is working closely with regional DHBs to re strengthen the DHBs' Healthy Food and Beverage policy and implementation plan. There is agreement in principle to update each DHB's Healthy Food and Beverage Policy to include a 'Water and Unflavoured Milk Only' policy. This will include: a. Preparation: DHB staff will work with retailers, staff and unions to prepare for the transition. This will include specific engagement with unions, including the RDA, SToNZ, ASMS and other health care worker unions. Mana Whenua engagement will be an important part of this Phase. It will also include increasing access to and promoting the availability of chilled tap water across DHB sites. b. Removal of cold drinks currently available under the 'Orange' category of the Policy – artificially-sweetened beverages and small-sized fruit juices, to only allow sale of 'Green category' chilled drinks (water and unflavoured milk) Alongside this, a thorough review of all aspects of the policy and refreshment of the implementation plan will be undertaken to ensure healthy food and drink environments.	Q2 Q4	Consultation complete Implementation by end of Q4
Healthy Active Learning ARPHS will be managing the Healthy Active Learning initiative on behalf of CM Health and the other metro Auckland DHBs and their contribution for this section is described below and will be reported through the ADHB Annual Plan		
2. Create support environments for healthy eating Health Active Learning Support early childcare education centres to establish food and drink policies to encourage healthy nutrition behaviours in the early years of life:	Q2	

Healthy food and drink environments		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
a. initial engagement with Auckland kindergarten association b. engage all kindergartens in the Auckland kindergarten Association (approximately 100 centres) in establishing a food and drink policy	Q4	

Smokefree 2025		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
1. With a particular focus on Maaori and Pacific people, outcomes related to harm from smoking will be improved by: - Continuing to focus on smokefree ABC in primary, secondary, maternity, mental health and community health settings. - An increase in referrals to cessation support. - COVID 19 response: Contactless Nicotine Replacement Therapy delivery, virtual access to prescription medications and virtual behavioural support to stop smoking. **(EOA)**	Q1-Q4	PH04: Better help for smokers to quit (primary care) CW09: Better help for smokers to quit (maternity) a. An increase in referrals to Living Smokefree Service by 15%. b. 45% of those supported to stop smoking are Maaori. c. 25% of those supported to stop smoking are Pacific. d. Pacific specific smokefree health/service promotion in workplaces, tertiary education centres and community services
2. Implement "Tobacco Free Generation (TFG) approach" projects in Counties Manukau, which will include **(EOA)**: - Pregnancy and whaanau Incentive Programme focused on pregnant women and babies living in smokefree homes. - Youth-led projects in schools, Alternative education, tertiary education and community settings to support young people to be smokefree (i.e. to never start smoking) with a particular focus on young waahine Maaori	Q1-Q4	a. An increase in participation in pregnancy and whaanau incentives programme by 10%. b. 60% of those supported to stop smoking through the pregnancy and whaanau incentives are hapuu waahine Maaori. c. Engage with 10 schools, alternative education and tertiary education in priority localities on TFG activities d. An increase of 25% in the number of young waahine

Smokefree 2025		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
		Maaori who successfully stop smoking

Breast Screening		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
1. Develop and implement an Equity Improvement Plan as required in the BreastScreen Service contract with the DHB.	Q4	Plan developed and implemented
2. Support COVID-19 response and recovery: Continue to ensure Maaori and Pacific are prioritised for appointments. This includes returning to pre COVID 19 re-invitation intervals for Maaori and Pacific women by ensuring Maaori and Pacific are re-invited earlier than "Others", at 22 months, specific follow up and reminder processes, running Mana Waahine days on Saturdays and reserving weekend slots for Maaori women. **(EOA)**	Q4	Maaori and Pacific women invited for rescreening at 22 months from 1 July 2021
3. Improve participation of Maaori waahine (Counties Manukau Health exceeds 70% participation for Pacific women) in the BreastScreen programme by following up all 100% not enrolled Maaori women identified through new PHO data matching reports. **(EOA)**	Q4	Report on % women followed up and outcome as % screened

Cervical Screening		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
1. Improve coverage for Maaori and Pacific women by working more closely with PHOs and GPs to provide assistance with calling and/or screening high priority group women.	Q4	# of Primary Care Practices where assistance provided.
2. Increase of community smear-taking clinics in locations with high Maaori, Pacific and Asian populations. This includes an increase in Mana Waahine Days, and extra weekend and evening clinics to make service more assessable Ethnic community health workers engaging with relevant groups to increase awareness	Q4	16 Mana Waahine Clinics held by June 2022. 24 evening/weekend clinics held by June 2022

Cervical Screening		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
3. Improve equitable access to diagnostic and treatment colposcopies for priority group women by working with the CM Health Screening Support Services to support follow up of priority women.	Q4	# of referrals to Screening Support Services, and % reached.

Reducing alcohol related harm		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
CM Health have an Alcohol Harm Minimisation Programme of work underway, two key focus areas being: - Pursuing equity in access to high quality and culturally-appropriate Alcohol ABC Approach (i.e. Ask, deliver Brief advice and offer referral to Counselling or other help). - Develop and deliver alcohol harm minimisation communication activities to CM health staff and CM community, including activities to raise awareness of FASD and the risks of drinking during pregnancy. **(EOA)**		
1. Enhance the Alcohol ABC Approach delivery in existing settings (General Practice, ED, Smokefree service, Hand Therapy outpatient clinic).	Q1-Q4	Enhanced delivery of ABC approach in existing settings
2. Implement the Alcohol ABC Approach in at least two inpatient wards.	Q4	ABC Approach implemented
3. Deliver at least two communication activities	Q2, Q4	Activities delivered
Actions to support the Public Health Unit to advance activities relating to reducing alcohol related harm, undertake enforcement of the Sale and Supply of Alcohol Act 2012, and achieve equitable outcomes for Maaori, ensuring programme delivery is underpinned by the Treaty of Waitangi and its principles for Pae Ora – healthy futures for Maaori.		
4. Evidence-based actions to reduce inequities in alcohol-related harm - Re-design ARPHS's compliance processes to consult with Ngaati Whaatua and Tainui on new bottle shop licence applications to give greater consideration and a stronger voice to Maaori needs when assessing applications **(EOA)**	Q4	
5. Compliance and enforcement Undertake compliance and enforcement activities relating to the Sale and Supply of Alcohol Act 2012 to help reduce alcohol-related harm. This includes delivering on the activities and reporting on the performance measures contained in the Reducing Alcohol Related Harm planning and reporting 2021/22 template (Vital Few Report) a. Assess all alcohol off licence applications received b. Provide Vital Few reports	Q1 and ongoing Q2, Q4	

Sexual and reproductive health		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Sexual health service provision is led by ADHB for the metro Auckland region, through Auckland Regional Sexual Health Service. Activities for this section are described below and within the ADHB Annual Plan.		
1. Support COVID-19 recovery/embed learnings Strengthen service capability to provide patients options. This enable careful triage management during changing COVID-19 alert levels to ensure continuity of care through telehealth and virtual channels a. Clinko system (a patient self-booking system) in place b. Streamline patient follow-up by offering virtual 15-minute follow-up consults for HIV PrEP	Q2 Q4	
2. Reducing inequities Review clinic locations in conjunction with community/local iwi representatives to ensure appropriate services are offered locally for Maaori and Pacific (EOA) a. Complete West Auckland review b. Complete South and North Auckland reviews	Q2 Q4	
3. Refine metrics that provide outcome data for patient populations to improve understanding of health outcome gaps, particularly for Maaori and Pacific patients **(EOA)** a. Embed metrics as part of service operating model b. Review metrics and complete clinical outcomes audit	Q2 Q4	
4. Implement point-of-care syphilis testing aimed at Maaori and Pacific in high needs areas to increase case detection (EOA) a. Define model b. Implement model	Q2 Q4	
5. Continue promotion/provision of mobile Youth Contraception and Sexual Health service, inclusive of Jadelle insertion by Registered Nurses prescribing in community health in schools, AEs, TPUs, as well as other community venues including Youthline and Te Kaha o Rangatahi a. Support at least 2 school based health services to trial quality improvement initiatives aimed at increasing utilisation of health service by male rangatahi with a focus on sexual health services	Q4	2500 young people receive contraception from mobile Youth Contraception and Sexual Health service in period July 2021 to June 2022. 10% increase in the number of male students accessing school based health services.

Cross Sectoral Collaboration including Health in All Policies		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Support COVID-19 recovery/embed learnings 1. ARPHS shares COVID-19 learnings with cross-sectoral organisations as appropriate Report on information shared	Q2, Q4	
Wider determinants of health ARPHS works in partnership with other cross- sectoral organisations across the Auckland region to support Health in All Policies to achieve equitable health outcomes (EOA), where resources and capacity allows 2. ARPHS leads the Healthy Auckland Together (HAT)[7] coalition. ARPHS provides the backbone function for the Healthy Auckland Together (HAT) collaboration, of which CM Health is a part of alongside both health and non-health sector partners. HAT is working to improve environments to support healthy nutrition, physical activity and obesity prevention, and includes Auckland Council, Auckland Transport, and University of Auckland, along with a variety of health sector partners. Their contribution for this section is described in, and will be reported through, the ADHB Annual Plan 3. ARPHS leads the Auckland Intersectoral Public Health Group (AIPHG)[8] Working with key stakeholders (the AIPHG group), ARPHS aims to improve whole-of-government responsiveness to public health issues in Taamaki Makaurau. The Healthy Auckland Together coalition aims to improve nutrition, increase physical activity and address obesity in Taamaki Makaurau. ARPHS ensures that HAT and AIPHG membership includes Maaori and Pacific representation	Q4 Quarterly	
4. To share ARPHS knowledge and expertise on public health topics and to promote Health in All Policies, ARPHS contributes to relevant regional and national policy development process on wider social and economic determinants of health. An equity lens will be applied to all submissions through the use of the Health Equity Assessment Tool (HEAT) to consider impacts on Maaori and Pacific populations **(EOA)**	As required	
5. ARPHS engages with the Metro Auckland DHBs on its newly developed Pacific Strategy. This in turn, will inform the development of the strategy's		

[7] Stakeholders: 32 organisations representing local government, mana whenua, health agencies, NGOs, university and consumer interest groups.
[8] Stakeholders: DHBs planning and funding representatives, Northern Regional Alliance, and Ministry of Health.

Cross Sectoral Collaboration including Health in All Policies		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
implementation plan. ARPHS' Pacific Strategy focus areas are community engagement, outbreak surveillance, Smokefree 2025, reducing alcohol harm and nutrition a. Engagement with Auckland DHB b. Engagement with Counties Manukau and Waitemata DHBs	Q1 Q2, Q3	
South Auckland Social Wellbeing Board CM Health is a key partner in the South Auckland Social Wellbeing Board (SASWB), originally one of three Cabinet mandated Place-Based Initiatives (PBIs). The SASWB partners, local and national decision-makers from 12 government agencies within and outside the health sector plus Auckland Council, who jointly fund many of the services and support whaanau receive, are working together to improve health and social outcomes for children and their whaanau in South Auckland. There is a focus on Maaori and Pacific whaanau. CM Health is also the organisational host for the SASWB staff who support the work of the SASWB (e.g. leadership, programme management, and evidence and insights). 1. CM Health to employ an Intersectoral funding manager to act as a linkage for CM Health services to the other agencies involved in the SASWB, and to act as a change champion for prototyping new ways of cross-sector working for Maaori and Pacific whaanau.	Q2	Intersectoral funding manager employed

2.5.6 Better population health outcomes supported by strong and equitable public health and disability system

New Zealanders are living longer, but also spending more time in poor health and living with more disability. People with disabilities experience poorer outcomes and face barriers to access to health and disability services.

This means we can expect strong demand for health and disability services in the community, our hospitals, and other care settings.

Responding to this challenge will require effective and co-ordinated care in the community supported by strategic capital investment, workforce development and joined-up service planning to maximise system resources; to improve system sustainability, to improve health, to improve accessibility and to reduce differences in health outcomes in a timely manner.

Delivery of Whaanau Ora		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
1. Refer to section 2.5.1 Maaori Health Action Plan. Accelerate and spread the delivery of kaupapa Maaori and whaanau-centred services for detail on whaanau ora services. 2. Refer to action 3. in Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-25 section below for detail on fanau ola services.		

Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Support the development and maintenance of real-time data and contact tracing for COVID-19 response to **(1) inform actions, initiatives, and policies, and** **(2) ensure contact tracing of Pacific cases is culturally appropriate and effective**		
1. Liaise with Pacific leadership networks, (e.g. MOH, Cause Collective, Pacific Advisory Group, Pacific DHB Managers Group) to access and monitor real-time data on Pacific COVID-19 cases within the Counties Manukau Health area. a. Dedicated staff allocated b. COVID-19 real time data system established	Q3	Dedicated staff allocated by Q3. COVID-19 Real-time data system established.
Improve communications for Pacific communities including **(1) Pacific health literacy and** **(2) dissemination of public health messages for Pacific communities**		
2. Ensure all Pacific people access culturally appropriate and timely public health messages and information via trusted and relevant communication channels. a. Pacific Health Development staff share trusted and relevant communication channels to Pacific people	Q1-Q4	Increased awareness of trusted and relevant communication channels among Pacific people
Ensure ongoing access to wraparound health and social services for Pacific families, especially those with complex needs		
3. Ensure Pacific patients with complex needs have access to culturally appropriate wraparound supports through the Fanau Ola service and contribution to the Social Assessment Meeting (SAM) project. This also includes Pacific patients and their families from the Pacific region. a. All referrals and their family care plans are completed. b. Pacific island patients and families access to wraparound services are supported.	Q1-Q4	Number of referrals and extra fanau members supported. Number of Pacific Islands patients supported Increase number of Pacific patients who are resilient and empowered to access and navigate through the health system.

Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
		Number of Safety Assessment Meetings (SAM) including both cases and those that were impacted. All referrals and their fanau were supported and are now Better Off (self-reported) compared to when they were referred to FOS, before they are discharged from FOS care
Maintain stronger governance relationships with the Pacific health sector, including DHBs, providers, clinicians, and community leaders		
4. Continue to strengthen the relationship with Pacific communities through various Pacific health sectors, PHO's, NGO's and community churches.	Q3	Community/church leaders network established by Q3. Contacts details of community leaders documented
5. Counties Manukau DHB to establish a governance relationship with Pacific leaders in the Counties Manukau community to align with the organisation's strategic objective to develop effective Pacific governance relationships across the system	Q4	Board establishes a formal governance relationship with Pacific leaders in the Counties Manukau community
Grow the Pacific health workforce and develop the cultural responsiveness of DHB services		
6. Growing the Pacific workforce pipeline of Pacific students training to be health care professionals from high school through to tertiary study. This is through growing the FOU (The Future is Open to Us) programme.	Q4	To increase the number of Pacific students in the Health Science Academy by 50%.
7. Increase Pacific Cultural Competency in CM Health services to improve engagement and experience with Pacific patients and their fanau. a. All departments make it compulsory for new staff to do the Pacific Cultural Competency Training	Q4	Number of staff at CM Health who participate in the Pacific Cultural Competency Training course.

Care Capacity Demand Management (CCDM)		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Key actions the DHB will undertake in 2021/22 to complete and/or maintain the implementation of CCDM in each component of the programme; governance, patient acuity data, core data set, variance response management and FTE calculations.		
1. Governance Every ward has the opportunity to engage in a local data council that produces quality improvement initiatives.	Q1 –Q4	Number of wards engaged

Care Capacity Demand Management (CCDM)		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
2. Patient acuity data Every ward meets the 3 TrendCare KPIs of being 100% IRR tested, 100% actualised and 100% of patient hours in benchmark so that TrendCare data can be used to inform FTE calculations	Q1 – Q4	Number of wards meeting TrendCare KPIs
3. Core data set Measures from the nursing core data set are reported from floor to board. This is achieved by monitoring the core data set at local data councils and CCDM council.	Q1 – Q4	Measures from the nursing core data set are reported from floor to board.
4. Variance response management Every ward participates in Variance Response Management to enable the best use of health resources and ensure the right staff are present at the right time.	Q1 – Q4	Number of wards participating in Variance Response Management
5. FTE calculations 75% of FTE Calculations will be complete and recruited to.	Q4	% of FTE calculations completed

Health outcomes for disabled people		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Implement actions from the CM Health Disability Strategy Action Plan -2019-2022 to improve the experience and health outcomes for disabled people through the following:		
1. Increase staff capability to provide high quality care that meets the needs of disabled people through staff training. CM Health has introduced a disability responsive training course for all staff. CM Health will continue to increase the percentage of staff undertaking training in disability awareness, by improving uptake of mandatory e-Learning on disability responsiveness and cultural competency training with a focus on disability. This cultural competency training also includes competence in working with Maaori and Pacific populations. **(EOA)**	Q4	50% increase in staff completing training by Q4
2. Reduce barriers to accessing health services by ensuring all new facilities are barrier free and promote a disability friendly environment. CM Health will ensure all new builds are fully accessible and remedial builds aim to improve accessibility	Q4	All building projects include universal design principles
3. Regularly engage with the disability community to ensure services are co-designed	Q4	Disability community is represented in consumer and advisory groups.
4. Ensure disabled people have easy access to COVID-19 vaccination and information in accessible formats	Q2 to Q4	Vaccination services cater to the needs of disabled people.
5. Enable the employment of disabled people within the health service. CM Health will identify and support ways to increase employment of disabled staff. CM Health will	Q4	Increase the number of disabled people employed at CM Health

Health outcomes for disabled people		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Implement actions from the CM Health Disability Strategy Action Plan -2019-2022 to improve the experience and health outcomes for disabled people through the following:		
collaborate with external providers to ensure the pathway is inclusive. **(EOA)**		

Planned care		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Planned Care is a broader concept than medical and surgical services traditionally known as Electives or Arranged services. Planned Care is patient-centred and includes a range of treatments funded by DHBs delivered in inpatient, outpatient, primary and community settings. It also includes selected early intervention programmes that can prevent or delay the need for more complex healthcare interventions. Over 2021/22 CM Health will continue efforts to achieve Planned Care intervention targets, increase clinical capacity and maintain timeliness and equity of access to Planned Care services (including diagnostics and radiology) in line with the National Planned Care Vision and key principles. In Q1, 21/22 CM Health will begin implementation of its Healthy Together 2025 strategy. This will include a Clinical Services Plan and Equity Plan which will take account of the Planned Care principles: • Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed • Balance national consistency and the local context • Support consumers to navigate their health journeys • Optimises sector capacity and capability • Ensures the Planned Care systems and supports are designed to be fit for the future		
COVID-19 recovery Planned Care delivery at CM Health has been significantly impacted by the Whakaari/White Island Eruption and COVID-19 in the last fourteen months. CM Health has already commenced work to recover Planned Care waiting lists from the impact of COVID-19, by scheduling catch-up clinics and elective surgery lists after hours. The final result for 2019/20 of achieving 95% of Planned Care (elective) discharges is a reflection of this effort in May and June 2020. While this has made some inroads, the three-year Improvement Plan submitted to the MOH outlines the full recovery plan inclusive of COVID-19 in addition to the plan to address the ESPI compliance. This is overlaid by the 3 year individual clinical services plans.		
1. Each service within Surgery will continue to work to year 2 of the 3-year Planned Care Improvement Plan that is inclusive of COVID-19 recovery. The following form the aspects of the plan to meet targets: a. Development of innovative models of care, patient centric care pathways and alternatives for outsourcing, as well as Nurse-led clinics and one-stop shop multidisciplinary clinics. b. Improving the use of Information Technologies (IT), such as telemedicine, electronic forms and other remote technologies, as per the Healthy Together Technology roadmap, and the use of technology-based	Q1-Q4	Quarterly reporting on performance on projected Waitlist / Access KPIs in Plan. KPIs: • Waitlist Numbers per speciality • Regain Elective Services Patient Flow Indicators compliance (ESPI 2 and 5). Production planning for each service

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dashboards as part of feedback loops to monitor performance metrics against targets. c. Operationalising Surgical Journey Optimisation Project. d. Production planning a. Health Intelligence – concerted effort to determine capacity and demand metrics for all outpatient modalities and for elective surgery. b. Optimising process redesign, capacity and demand initiatives for outpatients.		• Decrease DNA Rates for Maori & Pacific populations • Patient Experience Feedback Meet > 90% of planned targets per Quarter
2. Use of the MOH additional funding for Planned Care to assist with COVID-19 recovery and the 3-year Planned Care Improvement Plan. A number of the projects have had delayed starts due to a number of factors including COVID-19 and will flow into 2021/22.	Q1-Q4	Meet targets and trajectories • Service Improvement Activity – meet > 90% of forecast delivery • Capital Expenditure - > 75% of forecast benefit (most delayed of projects) • Sustainability - > 80 % of forecast benefits
Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed		
3. Continuation of Ophthalmology Improvement Programme: - Reduce the CPAC Score for wait listing for Cataract surgery from 55 to 50 to give access to 340 more patients for surgery per year and reduce geographic inequity for CM Health population. - Continuing of additional clinics on weekends and evenings for FSAs and Follow-up (FU) appointments and Avastin injections and outsourcing to address CM	Q1-Q4	SS07 (Ophthalmology) ESP1 and ESPI 5

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Health capacity shortfall via wet anlease at Surgery South and full outsourcing.		
Balance national consistency and the local context		
1. Reviewing the CPAC score threshold for wait listing for surgery across the Northern Region to identify inconsistency and try to address geographic inequities: further reduce the CPAC score for Ophthalmology from 50 (as above) to 48.	Q1-Q3	Q1-2 - Meet >90% of improvement in the projected increase of patients accessing cataract surgery. Review if feasible by Q3 to reduce CPAC score to 48.
2. Use lessons learnt from the Ophthalmology improvement initiatives, to review the CPAC threshold for Orthopaedics for joint replacement, this is currently 65 in CM Health and 45 and 50 in ADHB and WDHB. This is a work in progress and will report on progress in end of Q1 2021/22.	Q1	Progress report on CPAC threshold complete in Q1
Support consumers to navigate their health journeys		
3. The Surgical Journey Improvement Project, Patient Experience Work Stream has carried out extensive consumer engagement via survey and face to face interviews with a focus on Maaori and Pacific to facilitate co-design and have identified as barriers to access: • Family /personal constraint • Interpreter availability/language barriers • Patient information/ education • IT solutions to improve quality a. Use of Telehealth to access interpreters (Zoom). (Improvement cycles in progress) b. Development of Language Boards (currently in design phase) based on Boards developed in Eastern Health – Melbourne c. IT improvements in Booking and Scheduling system to improve quality of service. This will link into the	Q1	Q1 will have assessed the percentage of appointments that can use 'virtual' Interpreters. Measure will be steady reduction in percentage cancellations and DNAs (with a focus on Maori and Pacific Populations) Q1 will have implemented a number of the Language Boards in agreed languages – measure will be patient and staff feedback and reduction in DNAs and improved Health Literacy

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Mailhouse project that aims to reduce the number of letters to patients by increasing access via email and giving access to electronic links to education and information for patients **(EOA)**		
Optimise sector capacity and capability		
4. The Surgical Journey Improvement Project, Theatre Work Stream looking at improving capability and capacity (current physical theatre capacity is constraint within CM Health) by improving efficiency: a. Increasing session utilisation, (unused session due to planned and unplanned) b. Reduce session cancellations c. Reduce day of surgery cancellations	Q1-Q4	Increase session utilisation from 90% to 95% Reduce Session cancellation by 40% Day of surgery cancellation by 30%-40%
Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future		
5. Plans for Grow Manukau Health Park and the planned theatre, CSSD and Outpatient expansion including Radiology and an Integrated Breast Unit supports a sustainable and fit for purpose design. Environmental and fiscal sustainability are an integral part of the Grow MHP Detailed Business Case including engaging with environmental consultants to obtain Green Star Rating for MHP facilities.	Q4 (Planning for opening in 3 years – interim plans in place to sustain services until 2024).	We will continue to report on the Grow Manukau project via monthly status reports to the MoH which includes details on project tracking such as: • Scope • Time • Budget

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		• Risks
6. Please refer to the Planned care improvements outlined above as part of the Surgical Journey Improvement Project for Planned Care sustainability. The improvement projects outlined above aim to maximise internal capacity through the use of additional weekend and evening clinics across all specialties and increased outsourcing and Wet Leasing to meet access targets and ESPI compliance as part of the 3-year Planned Care Improvement Plan.	Q1-Q4	Monitor SS07 Measure 1 and 2 (ESPI 5) on total Planned Care Interventions and ongoing per quarter reporting. Monitor SS07 Measure 2 and 4 (ESPI 2 and FU for Ophthalmology) Meeting the trajectories outlined in the 3-year Planned Care Improvement Plan. Acute readmission rate Patient experience of care
Planned Care Interventions (SS07)		
7. Agree the Total Planned Care Interventions with MOH for SS07: Planned Care Interventions – Measure 1 8. When setting the required PVS / WEIS / Discharges for 2021/22 and delivery of same, the impact of COVID-19 recovery, the 3-year Planned Care Improvement Trajectory will need to be taken into account.		20,185 Inpatient Surgical Discharges 10,611 Minor Procedures 326 Non-Surgical Interventions - SS07 Measure 2 ESPI 2 and 3 - SS07 Measure 4 Ophthalmology FU Waiting Times
9. Collaboration across the Northern Region through the Vulnerable Service Groups with a major focus on Equity **(EOA)**: • *Ophthalmology* • *Sarcoma*		- Consistency in CPAC Score for Cataract - Community Outreach Specialist Eye Services

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• *Oral Health* • *ORL / H&N – Paeds & Adult* • *Vascular*		- Enhancing Cataracts e-Referrals KPIs will be measured as per Project Targets

Acute Demand		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Acute data capture: SNOMED		
1. SNOMED is a set of internationally recognised diagnostic codes. The MOH has mandated this is introduced nationally as a consistent way of coding emergency department chief presenting complaint, any associated patient procedures and an ED discharge diagnosis. A feasibility/testing phase will be introduced in Q2 2021-22 which will capture the Chief Presenting Complaint in the Emergency Department. Capture of SNOMED coding for LTCs is within the scope of the Regional Community Collaborative Care (RCCC) programme of work in progress which is currently in the vendor negotiation phase with a likely implementation in 23/24.	Q2	
In 2021/22 CM Health will actively manage growth in acute inpatient admissions through:		
2. Increasing acute capacity to reduce acute medical demand by reviewing all available space in the Middlemore site, including refurbishing older facilities	Q3 and Q4	Days with medical occupancy >100%
3. Transferring less acute patients to Pukekohe Hospital to fully utilise the 20 available inpatient beds.		

Acute Demand		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
4. Increasingly efficient utilisation of existing bed capacity through initiatives to maintain efficient and effective care: a. Extended hours of GP access to specialist medical phone advice regarding admission decisions, b. Improved capacity and capability of Acute Medicine Rapid Access Clinic (AMRAC) to provide alternatives to admission c. Continued development of non-hospital related capacity and capability to provide alternative options to acute hospital based admission, e.g.; admission to Hospital in the Home (HiTH) direct from Medical Assessment (MAU), to prevent acute hospital admission. d. Ensure the period of time between the decision to admit and the decision to medically clear for discharge is as efficient and streamlined as possible to prevent prolonged hospital stay, keep patients well, avoid hospital acquired harm and prevent/reduce risk of unnecessary readmission. e. Minimising unnecessary and avoidable delays to discharge through initiatives such as rapid access to diagnostics (e.g. ECHO and endoscopy) to reduce length of stay. f. Anticipating socially complex discharge barriers early, i.e. at point of admission and planning appropriate non-medical interventions in parallel with medical care: e.g.; initiating PPPR requirements early, confirming EPOA on admission, utilising POAC options/Taikura Trust Service Providers for residential placement to support earlier family decisions where possible. Meeting with Taikura Trust to prevent delayed discharges. g. Navigate available care pathways with support of the Maaori and Pacifica Health Units to ensure timely and equitable access to and discharge from acute services. **(EOA)**		
5. Development of Middlemore Central Dashboards to provide real time bed and pressures status to manage patient flow.	Ongoing 2021/22	
6. Utilising a revised bed escalation process to proactively manage system pressures and trigger action as required.	Q1	
7. Start the development of a patient bed management system to increase visibility of blockages to patient movements along their pathway	Q1	
8. Consideration and evaluation of the use of Emergency Q on ED attendances and potentially on acute admissions	Q1	
Improving wait times for patients requiring mental health and addiction services who present to ED		
9. Mental Health & Addictions (MH&A) Crisis Support Capability Planning.	Q1	Baseline Data analysis of MH&A and acute distress presentations to ED completed

Acute Demand		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
MH&A and ED services will develop and embed screening tools, pathways, and resources to improve staff capability to assess and treat those presenting at ED with complex and challenging behaviours and complex comorbidities.	Q2 Q4	Global Café recommendations completed Improved model of care including integrated pathways for acute behavioural disturbances completed
Identifying and address inequities when accessing emergency departments		
10. Middlemore ED is in the process of implementing the ACEM (Australasian College for Emergency Medicine) developed Manaaki Mana strategy. Two of the authors of the strategy are SMOs within the ED and leading the implementation, including: o A twice yearly hui o Specific RMO teaching o Increased Maaori language usage The next steps will be developed at the upcoming Hui a. Audit of outcomes from ED care b. Liaison with Maori Health regarding the Maaori Mobile Nurse in the department.	Ongoing	Percentage of Manaaki Mana strategy implemented Ongoing development of set of indicators specifically looking at unequal outcomes for Maaori
Better population health outcomes in partnership with primary health care		
11. Review access to subsidised after hours care to ensure there are timely acute care options that improve equity of access for high needs populations. **(EOA)**	Q1-Q2	Conduct review of afterhours model of care and implement changes by Q2

Rural health		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
1. Implement the COVID-19 vaccination programme across the community ensuring that it is taken up by Maaori and Pacific people at equal or higher rates than other populations and there are equitable opportunities to receive the vaccine regardless of location.	Q4	Roll out across the CMH region covers rural and remote populations
2. Utilise the Rural Service Level Alliance Team (SLAT) to review rural primary care services in Franklin to support equity of access (enrolment and utilisation) for Maaori and commission new services with the DHBs rural funding allowance. This will build on one of the Te Ranga Ora Prototype Collectives co-design work findings and is likely to include better ways to support patient/whaanau choice or provider and virtual care options.	Q2	Stock take completed

Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022

Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
National process to improve preparedness for a pandemic outbreak (and COVID-19 resurgence) on services in the community for older people		
1. Support and facilitate the COVID-19 vaccine roll out to Aged Residential Care (ARC) and Home and Community Support Service (HCSS) providers 2. Support ARC and HCSS providers to maintain preparedness to effectively respond to COVID-19 (and other infectious disease) outbreaks	Q1 Ongoing	Roll out complete for both vaccine doses to all metro Auckland ARC facilities
Community and primary care: improve the identification of factors associated with early signs of emerging frailty, with a focus on Maaori and Pacific peoples		
3. Undertake a review and implement recommendations from interRAI DIVERT pilot - which involves referral of all clients with an interRAI assessment DIVERT score of 5-6 to Community Geriatric Services for review with the aim to decrease rate of admission. Post pilot analysis will include review of ethnicity data.	Q1 Q2	Review outcome of pilot Implement recommendations
Dementia services		
4. Review the uptake of the use of the regional dementia pathway across 4 GP practices with CM Health including a Maori and a Pacific island practice. Review to include how many patients are diagnosed with Mild cognitive impairment (MCI) 5. Investigate the feasibility of the MCI pathway being adopted by primary care. Identify any barriers and how CM Health can support these practices.	Q2 Q3	Identification of potential barriers Ethnicity data re numbers diagnosed with MCI across four practises
Early supported discharge services and community-based support and restorative services		
6. Implementation of national home and community support services service specification and restorative model of care.	Q4	Implement National HCSS Service Specification by June 2022

Health quality & safety (quality improvement)		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Spreading hand hygiene practice		
1. Deliver hand hygiene performance reporting to services a. CM Health Performance Report: Hand Hygiene distributed to all services at CM Health with reflection and action points documented b. Monthly hand hygiene compliance updates to reflect compliance by area based on Moments and Health Care Worker groups	Q1-Q4 Q1-Q4 (report produced monthly)	80% target achieved 100 moments collected by the end of the month for all clinical areas unless otherwise negotiated to collected a smaller number of audits
2. Hand hygiene education	Q4	100% attendance and completion

a. Online learning modules for all Health Care Workers b. Targeted education for healthcare worker groups c. Support students from tertiary institution education d. Training of Gold Hand Hygiene Auditors to maintain a pool of hand hygiene auditors for all clinical areas	Q1-Q4	6 times per year.
Improving equity		
1. Please refer to Te Ranga Ora under the Primary Health Care section on Page 71 of this Annual Plan for activities targeted towards models of care to engage and support people and whaanau living with Long-Term Conditions (LTCs), including Diabetes. COVID-19 has provided lots of learning on what is possible and the five Collectives are utilising this learning as they co-design the future models of care. The updates on Te Ranga Ora will be provided under the Primary care section.		
Improving Consumer engagement		
1. Identify evidence suitable for QSM report via quarterly stocktake	Q1 and Q3	Evidence is aligned to SURE framework and describes consumer engagement
2. Quarterly report to QSM Governance Group and Consumer Council on QSM implementation and proposed evidence	Q1 and Q3	Reports available
3. Report to HQSC at prescribed report dates	Q1 and Q3	Report on QSM

Te Aho o Te Kahu – Cancer Control Agency		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
New Zealanders have a system that delivers consistent and modern cancer care – He puunaha atawahi		
1. We will support and proactively engage with the development and implementation of a Regional Oncology Electronic Prescribing System. We will do this as part of a Regional alliance, through membership on the steering and implementation groups and supporting the workforce that will be required to implement and embed the system	Ongoing Q1-4	
2. We will support and proactively participate in the Regional Radiation Oncology Working Group that is developed to commence a process that agrees the intended location of future LINAC and make recommendations to the Regional Executive forum of preferred locations to enable capital, facility and service planning to commence. We will use population and ROCK data to determine the delivery of service and numbers of patients we are meeting the needs of through intervention rates. In addition we would be considering what kind of treatment would be provide in satellite sites and enabling equitable access.	Q1-2	
3. We will continue to support compliance with the Multi-Disciplinary Meetings Care Pathway according to HISO		

Te Aho o Te Kahu – Cancer Control Agency		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
standards. Role out to the Lung tumour stream followed by Gynaecology tumour stream will commence in 21/22		
New Zealanders experience equitable cancer outcomes – He taurite ngaa huanga		
4. We will consider the Te Aho o Te Kahu report and recommendations based on feedback from 15 Maaori community hui and agree an action plan that addresses inequalities and access to diagnostic services.	Q1	
5. We will undertake a co-design approach of community hui and consumer engagement workshops to understand the needs of the community. This will be used to inform the development of cancer services.	Q1-Q2	
6. We will support the regional cancer work plan to implement agreed interventions to improve equity of access and outcomes, prioritising Lung and Uterine Cancer.	Q1-4	
New Zealanders have fewer cancers – He iti iho te mate pukupuku		
7. ***Smokefree 2025*** *– This is addressed in section 2.5.5 Improving Wellbeing through Prevention*		
8. ***Breast Screening*** *– This is addressed in section 2.5.5 Improving Wellbeing through Prevention*		
9. ***Cervical Screening****– This is addressed in section 2.5.5 Improving Wellbeing through Prevention*		
10. ***Bowel Screening –*** *This is addressed in section 2.5.6 Bowel screening and colonoscopy wait times*		
New Zealanders have better cancer survival, supportive care and end-of-life care – He hiki ake i te o ranga.		
11. We will revise and update the DHB Bowel Cancer Quality Service Improvement Plan following publication of the second national bowel QPI results in Quarter 3.	Q3	
12. We will develop a DHB Lung Cancer Quality Service Improvement Plan based on the results of the Lung Cancer Quality Improvement Monitoring Report (QPI 2020) and the impending Lung Cancer Quality Improvement Plan (2021). This will include a focus on late stage diagnosis following emergency presentation and will align with the regionally agreed cancer work plan focusing on Maaori	Ongoing Q1-4	
13. We will develop a DHB Prostate Cancer Quality Service Improvement Plan based on the results of the Prostate Cancer Quality Improvement Monitoring Report (QPI 2021) and the impending Prostate Cancer Quality Improvement Plan (2021). We will use the data from the report to inform areas where the DHB is outside the national average and use the to drive service improvement	Q3-4	
14. The DHB will continue to ensure the 31-day and 62-day cancer treatment wait time measures are met. We will work in partnership with Te Aho O Te Kahu and the Ministry of Health to improve FCT data quality and business rules changes as required.	Ongoing Q1-4	

Te Aho o Te Kahu – Cancer Control Agency		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
15. DHB contingency plans for COVID-19 will be maintained and reviewed regularly to ensure minimal impact on cancer diagnostic and treatment services in the event of a COVID-19 resurgence.	Ongoing Q1-4	
16. We will continue to support compliance with Multi-Disciplinary Meetings Care Pathway according to HISO standards. Roll out to the Lung tumour stream followed by Gynaecology tumour stream will commence in 21/22	Q1 Q2	Lung Gynaecology

Bowel screening and colonoscopy wait times		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
1. Maintain production planning process to ensure colonoscopy timeliness targets are met. Continue to outsource as per demand and to support in-house production and attainment of performance KPI's.	Q2 and Q4	Report - wait times. All recommended and maximum colonoscopy wait times are consistently met for urgent, non-urgent and surveillance procedures.
a. All recommended wait times targets are met for urgent, non-urgent and surveillance colonoscopies by Q2 2021/22 b. All maximum waiting times are met by Q3 2021/22	Q2 Q3	
2. Contribute to increasing coverage in the NBSP by carrying out bowel screening outreach activities as resources permit, including data matching with practices with high proportions of Maaori and Pacific populations, including Marae based Whare Ora Clinics, to identify and follow up priority participants who have not returned a test kit. Note that achieving target participation is a shared role with the DHBs, National Co-ordination Centre and the MOH.	Q2 and Q4	100% of priority participants identified through practice data matching followed up. Report number / % of practices data matched and outcomes; outcomes report to include the number of Maaori and Pacific participants who returned a kit.
3. Continue to meet time to first offered diagnostic assessment target for NBSP, through active monitoring of waitlists and resources available.	Q4	95% of participants offered diagnostic assessment within target timeframes.
4. Ensure equitable access to assessment services for NBSP participants through the provision of support and transport as required.	Q4	Report number of participants supported to appointments.

Health workforce		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Use the health workforce differently, both locally and regionally, as a result of the learnings from the COVID-19 response & **Union engagement when considering or developing any new initiatives to increase workforce flexibility and mobility in order to respond to COVID-19 &** **Using the workforce differently to sustainably build and/or support the swabbing/vaccinator workforces**		
1. In consultation with unions and staff, review the best support model for clinical staff operating in Managed Isolation Facilities	Q2	Review complete
2. Develop model of training of non-traditional workforces for vaccination, inclusive of supervision requirements, engaging with unions to assist	Q2	Model developed and implemented
3. Implement the Step Up programme - a literacy education programme for Kaiaawhina (unregulated) workforce which helps build confidence, teamwork and intercultural awareness	Q4	4 cohorts completed 40hrs of peer support delivered per person
4. Utilising casual staff more flexibly: Create regional working group, inclusive of union representation Review and analysis of casual employment arrangements Recommendations made and agreed and pilot underway	Q1 Q2 Q4	Regional working group formed Review complete
Increase the diversity of representation in leadership or decision-making roles		
5. Identifying Maaori and Pacific who can be rapidly developed to move into key clinical leadership roles 6. See also Whakamaua Action 2.3 and 3.1	Q4	Comparison at 30 June 2021 and 2022 Action plan developed with Clinical Chiefs
Sustained improvement in the number of professionals meeting standards of cultural competence and safety		
7. Utilise the Te Arawhiti individual competency standards as a basis to improve Maaori cultural competency amongst employees 8. See also Whakamaua Action 3.3 and Ola Manuia Action 7	Q4	75% staff have reached 5 competency standards
Support the sustainability, and the health and safety/wellbeing including mental wellbeing of your workforce.		
9. Participation in the Health Round Table Wellbeing Index in 2021/22 including survey for nursing staff	Q1 Q4	Targeted action plan for ED Measure effectiveness of plan
10. Continue development of staff support mechanisms and normalize debriefing through Swartz Rounds	Q4	Completion of 6 Schwartz rounds
11. Identify improvement strategies focussed on stress and fatigue amongst our workforce	Q1 Q2 Q3	Implement winter wellness resources and seminars underway Financial wellness workshops underway 'Stress first aid' workshops started

Health workforce		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Supporting work health & safety		
12. Completion of project to upskill Leaders, Board & Health and Safety Representatives via approved Health & Safety training.	Ongoing	The Employers and Manufacturers Association Health and Safety workshops held

Data and digital enablement		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
Support COVID-19 recovery/embed learnings		
1. Shift regional COVID data/ dashboard to cloud: Re-platform regional data store and dashboards onto cloud services to strengthen regional analytics. This re-uses the Ministry of Health national COVID-19 surveillance platform design and data.	Completed Q1, in place by Q2	
Actions with the most significant impact to address and resolve significant initiatives delayed by COVID-19		
2. Waitlist visibility by DHB and ethnic group: Publish interactive visualisations of regionally aligned, current waitlist data by ethnic group. COVID-19 preparation necessitated delays in a wide range of procedures for patients. This work will reveal the patient groups affected and allow DHB comparisons, leading to greater equity of access to procedures.	Q1	Availability to all DHBs by Q1
Most important actions to improve equity of access to health services via digitally enabled means (e.g. telehealth)		
3. Online Booking: Establish Patient Online Booking and Scheduling to give greater patient choice, especially important to priority population groups with less flexibility in attending clinics. The online booking system will enable a telehealth choice as well as booking time choice	Pilot by Q2 In place by Q4	Online booking system in place by Q4

Implementing the New Zealand Health Research Strategy		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
1. Prioritise internal research funding towards projects relating targeting COVID recovery.	Q4	Minimum 2 funding rounds launched by Q4.
2. Locality approval of research projects relating to COVID recovery.	Q4	10 research projects approved by Q4.

3. Provide research workshops to build and develop the capacity and capability of DHB staff in research skills and methodologies, that staff in other DHBs in the region may attend. Focus on issues of equity in ethics and qualitative research workshop.	Q4	20 research workshops provided by Q4.
4. Attendance National Research Office Managers group (ROMA) to encourage sharing of research-related innovation, such as Research Registry, standardisation of some research approval processes.	Q4	4 ROMA meetings attended and a regional innovation achieved by Q4.
5. Provision of annual "Research Week", an event which allows DHB staff to connect with each other, present their research work, and hear from inspirational research leaders. Equity themed presentations will be prioritised.	Q4	Research Week provided in 2021 and 2022
6. Applications to HRC for Career Development Grants to develop staff research capability, for projects that include a focus on issues of equity.	Q4	Minimum 2 Staff funded by HRC Career Development Grants to develop research competency in 2021-2022.

2.5.7 Better population health outcomes supported by primary health care

Primary health care is a priority work programme for Government, the Ministry of Health and District Health Boards.

An affordable effective primary care system is essential to achieving the objectives of a strong public health system. Primary care is the means through which the health system can decrease use of expensive secondary health services, better manage and lower the incidence of long-term conditions, increase use of illness-preventing behaviours and treatments, and thereby increase people's ability to participate in work and education.

Primary health care is earlier, safer, cheaper, and with improved continuity of care better connected to people's daily routines However, the primary health care system does not serve all people equitably. Some people are delaying access to primary care services for several reasons including cost, travel, time off work or arranging childcare. There is also the potential for a different primary care model to better suit people's lives and better integrate across health disciplines and facilities, thereby improving health outcomes.

Primary care

Te Ranga Ora

Te Ranga Ora will see the development of comprehensive, culturally-capable services and models of care for Maaori, Pacific People and people living in quintile 5 with two or more long term conditions. Models will be co-designed and delivered in partnership with local communities and delivered across the Counties Manukau rohe in a phased approach. Te Ranga Ora will be supported by CM Health in collaboration with the Ministry of Health, Ministry of Social Development and Kaainga Ora.

Five prototype collectives have been selected through a Request for Proposal process: Te Kakano, Te Kootuinga Hauora, Te Ora Puawai, Warm Exchange Plus, the Pacific Consortium. As the Te Ranga Ora programme expands, more Collectives will be added. The aim is to work in partnership to enable people in local communities to access a responsive, integrated range of wellness, health and social services close to their homes and their whaanau. People will see their culture and what matters to them reflected in the care and support that they receive.[9]

Government theme: Improving the wellbeing of New Zealanders and their families

Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
1. Implement the COVID-19 Vaccination and Immunisation Programme across the community, ensuring it is taken up by Maaori and Pacific people at equal or higher rates than other populations.	Ongoing	Monitoring the percentage of COVID vaccinations completed for PHO enrolled populations
2. Support primary care to deliver the COVID-19 vaccination programme where assistance is required to ensure sustainable delivery	Ongoing	The percentage of General Practices providing vaccinations
3. CM Health to explore options for provision of accessible, affordable primary care services in vulnerable, high growth areas where primary care coverage is low (e.g. through DHB provision or joint ventures with Maaori and Pacific providers)	Q1	Proof of concept options developed by Q1
4. Develop and implement five place based models of care with 'Te Ranga Ora' Prototype Collectives that enable local community leadership and determination over the co-design and implementation process, foster collaborative relationships and take strengths based approach. **(EOA)**	Q2	New integrated primary and community co-designed LTC models of care developed by Q2

Pharmacy

Government theme: Improving the wellbeing of New Zealanders and their families

Government priority outcome: Support healthier, safer and more connected communities

DHB activity	Milestone	Measure
1. Utilise community pharmacy to support COVID-19 response and recovery in particular by ensuring equitable access to medicines and pharmacy services is maintained during changes to alert levels.	Ongoing	No reduction in medicines dispensing during periods where COVID alert level is above 1.
2. Implement key local strategies to improve vaccination rates by raising awareness and promote pharmacy and other immunisation providers to improve influenza and measles vaccination (and possibly COVID-19 vaccination) with a	Q4	Increase number of vaccinating pharmacies in district to 60. Funded influenza vaccinations given in pharmacy will be 20%

[9] More information on Te Ranga Ora can be found on the CM Health website

Pharmacy		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
focus on high priority populations e.g. Maaori, Pacific people who are eligible for funded vaccination **(EOA)**		more in the proportional uptake by Maaori and Pacific people compared to 2021.
3. Continue to expand 'Owning My Gout' pharmacy service, widen access to more pharmacies in high Pasifika areas, increase GP buy-in and increase uptake by people with gout.	Q4	Ten pharmacies in areas with high priority patients (Maaori, Pacific, quintile 5) provide care to at least 140 patients in total, by Q4.

Reconfiguration of the National Air Ambulance Service Project – Phase Two		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
The DHB is committed to the 10-year plan to achieve a high functioning and integrated National Air Ambulance service and will participate through the National Ambulance Collaborative to implement Phase II. The DHB: • will support the implementation of changed governance arrangements to include DHBs to effect improved partnership with MOH and ACC in all elements of leadership of the NASO work programme, including identifying appropriate nominees, participating in meetings and workshops, provision of information in a timely manner • supports the development of a robust national process to develop a national tasking service		

Long term conditions		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
1. Please refer to Te Ranga Ora under the Primary Health Care section on page 71 of this Annual Plan for activities targeted towards models of care to engage and support people and whaanau living with Long-Term Conditions (LTCs), including Diabetes. COVID-19 has provided lots of learning on what is possible and the five Collectives are utilising this learning as they co-design the future models of care. The updates on Te Ranga Ora will be provided under the Primary care section. **(EOA)**		
2. Implementation and continued service improvement of an enhanced Green Prescription service that is accessible, culturally appropriate and incorporates more self-management components. For example, provision of healthy lifestyle support via phone, Zoom/online, webinars through healthy lifestyle advisors, phone support collaborative and registered Dietitians/Nutritionist.	Q2	Proportion of engaged adults in target population (Maaori, Pacific, Q5, pregnant women and people with mental health condition

Long term conditions		
Government theme: Improving the wellbeing of New Zealanders and their families **Government priority outcome:** Support healthier, safer and more connected communities		
DHB activity	**Milestone**	**Measure**
3. Implementation of a Healthy Weight Change in Pregnancy card. This card contains four key messages for healthy weight change in pregnancy. It specifies the recommended weight change for her BMI and allows her to plot her weight change on the graphs produced by the Institute of Medicine. It is a visual guide to empower her to maintain the appropriate weight change for her BMI. This card was co-designed with consumers when initially developed but has not been in a format to allow easy uptake in the community.	Q4	Card developed and in use by Q4
4. Work alongside PHOs and general practices to carry out a retinal screening data match and recall project that identifies and recalls patients with diabetes based on priority criteria (HbA1c and ethnicity).	Q3 and Q4	Project completed by Q3. Improved screening rates for Maaori and Pacific populations and people with Priority scores 1 & 2 by Q4
5. Develop a diabetes education package to be implemented in primary care that will foster team based care (i.e. Practice nurses, health coach, health improvement practitioners and pharmacist) for those with diabetes. Following the completion of the education package, health professionals will have improved understanding of Maaori and Pacific cultural frameworks, support services for onward referrals (SME, podiatry and retinal screening).	Q2	Education package developed and training completed by Q2
6. Implement a regional Hepatitis C test and treat programme, which will particularly focus on improving numbers tested and treated for Maaori **(EOA).**	Q4	Programme implemented by Q4.
Focus on: Ambulatory sensitive hospitalisations (ASH adult) (SS05)		
1. Please refer to the SLM Improvement Plan. The key areas of the SLM plan for addressing long term conditions are: a. Increase cardiovascular disease risk assessment rates for Maaori b. Increase Primary Options for Acute Care (POAC) initiation rates in Primary Care for ASH conditions, especially CHF, COPD and cellulitis		

2.6 Financial performance summary

CM Health remains fully committed to achieving the Government's priorities, despite the increasing fiscal constraints the health sector is facing. Capacity pressures associated with unprecedented growth in the demand for clinical services have placed significant strain on current budgets and staff across the system. Even when allowing for implementation of change and innovations to increase efficiency, projected increases in demand across the health system in the coming years will be difficult to accommodate whilst maintaining fiscal sustainability. We also continue to accommodate cost pressures with respect to current Multi Employer Collective Agreements (MECA). Sector pay restraint assumptions have been incorporated in FY22 and outer year forecasts.

While CM Health is pleased to have received an additional $108m Population Based Funding in the 2021/22 year, an estimated 7,000 of CM Health's population remains unfunded, amounting to a funding shortfall of ~$19.8m. In the 2021/22 year, of the $120m million of additional funding received (PBFF and other funding streams i.e. ACC, MoH MECA, planned care and CFA agreements outside PBFF), $64m (59%) of new funding is committed to price increases, $62.2m committed to volume or demand driven growth in mental health, primary and community services and critical hospital capacity. This essential cost growth cannot be adequately funded by new revenue and will need to be met by an ambitious savings target of $23.5m.

The impact of the DHB's response to COVID-19 through FY 20 and 21 has seen continued deployment of a significant number of DHB staff away from normal roles. The ongoing nature and urgency of this work has taken its impact on the delivery of the DHB's strategic programmes to achieve best value from the health system, notably the Every $ Counts (E$C) sustainability programme. This has resulted in a higher underlying cost structure carried forward into the FY22 year. In a deliberate strategy to achieve full value from resources already invested, services have been asked to absorb population growth where possible, limiting new capacity to those areas with highest clinical risk.

The current plan reflects a "standing still" underlying deficit of $29.7m (An additional provision of $20m is added to this recognising ongoing cost of compliance with the Holiday's Act). This plan represents best the attempt to prioritise across "short, medium and long term (transformational)" investment to align with our strategic priorities. The previous three budgets (FY 2018/19 - 2020/21) have taken a risk management approach to ensure that critical clinical risks are managed through limited investment in additional clinical capacity and initiatives to help manage demand growth. This has required considered trade-offs in what was chosen to be prioritised in the budgets. The proposed "standing still" budget position for 2021/22 continues to take this approach to ensure that ground is not lost on the improvements we have made in addressing clinical demand; reducing the 2021/22 budget further than the $29.7m deficit figure would be difficult to achieve without compromising our position with regards to maintaining clinical capacity to meet demand growth, and maintaining current thresholds for, and access to, treatment (i.e. "going backwards").

A "standing still" budget does allow for a level of critical risk reduction and growth in capacity to address acute demand which is now crowding out elective and planned care. Investment in the Board and organisational priority areas of equity and population health are less than desired.

CM Health acknowledges the expectation from the MOH to work towards an underlying breakeven position. The Board and Executive team, together with the Mana Whenua Board, will continue to consider trade off decisions to balance expectations set by the Minister of Health against its obligations to balance value, risk, equity and sustainability on behalf of the community it serves.

Statement of comprehensive income

Net Result	2019/20 Audited Actual	2020/21 Unaudited Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$ 000	$ 000	$ 000	$ 000	$ 000
Revenue						
Ministry of Health	1,726,278	1,920,035	1,938,928	2,063,180	2,167,100	2,276,067
Other Government	38,478	49,338	49,243	50,656	51,809	53,153
Other	41,817	41,516	44,395	45,698	46,753	47,826
Inter DHB and Internal	83,049	66,973	78,585	82,266	86,286	90,322
Total Revenue	**1,889,622**	**2,077,862**	**2,111,151**	**2,241,800**	**2,351,948**	**2,467,368**
Expenses						
Personnel	765,151	821,131	850,996	907,536	973,465	1,028,361
Outsourced	107,647	123,156	117,866	136,908	113,833	112,683
Clinical Support	131,630	143,971	139,217	148,635	152,971	158,295
Infrastructure	86,641	88,130	86,628	89,077	92,003	93,932
Personal Health	554,227	587,290	626,761	656,882	684,764	713,692
Mental Health	68,928	75,996	80,897	84,310	87,839	91,473
Disability Support	152,542	158,810	178,493	187,886	198,111	209,037
Public Health	25,915	54,338	7,578	7,888	8,207	8,535
Maaori	2,826	2,909	2,991	3,114	3,240	3,369
Operating Costs	**1,895,507**	**2,055,731**	**2,091,426**	**2,222,236**	**2,314,433**	**2,419,377**
Operating Surplus / (Deficit)	**(5,885)**	**22,131**	**19,725**	**19,564**	**37,515**	**47,991**
Depreciation	40,136	40,872	45,695	49,066	57,545	71,908
Capital Charge	33,625	24,986	23,511	24,975	29,827	37,263
Interest	25	99	242	329	315	300
Net Deficit	**(79,671)**	**(43,826)**	**(49,722)**	**(54,806)**	**(50,172)**	**(61,480)**
Other Comprehensive Income	-	86,228	-	-	-	-
(Deficit) / Surplus	**(79,671)**	**42,402**	**(49,722)**	**(54,806)**	**(50,172)**	**(61,480)**

Note: *Included in the 2019/20 audited result is an additional provision of $36.5m for the remediation of the areas of non-compliance in terms of the Holiday's Act that was not included in the budget. The 2021/22 plan includes an additional provision of $20m in terms of the Holiday's Act. The profit and loss for 2020/21 year included in the financial tables is the forecast year end position and is unaudited at the time of this publication.*

Note: *The 2022/23 plan includes a revenue correction assumption of $19.8m for the full correction of the estimated 7,000 uncounted population in the DHBs PBFF Revenue.*

Note: *A funding increase assumption of $108m has been top sliced for Mental Health Ring fence and Inter District Flows. The residual balance will be allocated to the Provider based on volumes, with the remainder allocated to Governance and Funder based on proportionate net surplus (deficit).*

Output classes

The following tables provide a prospective summary of revenue and expenses by Output Class.

Prevention

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**49,125**	**50,532**	**51,938**	**52,137**
Personnel costs	21,178	21,601	22,033	21,601
Outsourced Services	1,921	1,960	1,999	1,960
Clinical Supplies	5,907	6,025	6,146	6,025
Infrastructure & Non-Clinical Supplies	1,109	1,132	1,154	1,132
Other	19,010	19,814	20,606	21,419
Total Expenditures	**49,125**	**50,532**	**51,938**	**52,137**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Early Detection & Management

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**304,351**	**317,263**	**329,900**	**342,810**
Personnel costs	813	829	846	829
Outsourced Services	74	75	77	75
Clinical Supplies	227	231	236	231
Infrastructure & Non-Clinical Supplies	43	43	44	43
Other	303,194	316,085	328,697	341,632
Total Expenditures	**304,351**	**317,263**	**329,900**	**342,810**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Intensive Assessment & Treatment

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**1,541,974**	**1,647,661**	**1,732,368**	**1,823,249**
Personnel costs	817,112	872,975	938,212	993,800
Outsourced Services	114,792	133,772	110,634	109,547
Clinical Supplies	140,626	150,785	157,357	167,724
Infrastructure & Non-Clinical Supplies	143,440	149,847	163,625	182,524
Other	375,727	395,088	412,712	431,134
Total Expenditures	**1,591,696**	**1,702,467**	**1,782,540**	**1,884,729**
Net Deficit	**(49,722)**	**(54,806)**	**(50,172)**	**(61,480)**

Rehabilitation & Support

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**215,701**	**226,344**	**237,742**	**249,172**
Personnel costs	11,893	12,131	12,374	12,131
Outsourced Services	1,079	1,101	1,123	1,101
Clinical Supplies	3,317	3,384	3,451	3,384
Infrastructure & Non-Clinical Supplies	623	635	648	635
Other	198,789	209,093	220,146	231,921
Total Expenditures	**215,701**	**226,344**	**237,742**	**249,172**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Total

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**2,111,151**	**2,241,800**	**2,351,948**	**2,467,368**
Personnel costs	850,996	907,536	973,465	1,028,361
Outsourced Services	117,866	136,908	113,833	112,683
Clinical Supplies	150,077	160,425	167,190	177,364
Infrastructure & Non-Clinical Supplies	145,215	151,657	165,471	184,334
Other	896,720	940,080	982,161	1,026,106
Total Expenditures	**2,160,873**	**2,296,606**	**2,402,120**	**2,528,848**
Net Deficit	**(49,722)**	**(54,806)**	**(50,172)**	**(61,480)**

3. Service Configuration

3.1 Service Coverage

All DHBs are required to deliver a minimum of services, as defined in The Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually. Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Maaori, Pacific and high-needs groups. Counties Manukau DHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services.
Counties Manukau DHB is not seeking any formal exemptions to the Service Coverage Schedule in 2021/22.

3.2 Service Change

The table below describes all service reviews and service changes that have been approved for implementation in 2021/22. This also includes service changes as a result of COVID-19. Counties Manukau DHB is committed to managing its functions in a way that supports the intended direction and anticipated national health system change programme.

Table 1

Service Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Additional clinical capacity to meet local population need	The 2021/22 year will see the implementation of a number of Board approved projects to improve clinical capacity. These include: • Expansion of gastroenterology suite • Expansion of in-centre dialysis & implementation of a second Cardiac Catheter Lab (3FTE) • Expansion of neonatal cots (8.6FTE) • 41 additional acute inpatient beds (33FTE) through re-design and reallocation of existing spaces Further consideration is being given to the relocation of the Infusion Centre from the Middlemore Hospital site to a non-acute site & also to lifting its capacity to provide a more local oncology service (4FTE). In addition, to meet the demands placed on clinical services, 30.7FTE clinical and patient facing roles have been agreed. The clinical services are supported by 9FTE additional roles across the enabling services e.g. clinical engineering, disability support.	• Reduce waiting times and reduce risk associated with longer than clinically acceptable waiting times • Improve the patient, family and whaanau experience • Provide more local care and reduce patient transfers to other hospitals • Improve the capacity of the hospital to meet peaks in acute patient demand • Improve regional capacity of available beds & cots as the population grows • Improve clinical outcomes, patient safety and quality of care	Local and Regional

Multi-employer collective agreement compliance	These FTE ensure that CM Health maintains compliance with previously agreed MECA requirements: • CCDM 27.4FTE • RMO Schedule Ten 6.6FTE	This investment honours the DHBs obligation to ensure safe staffing.	Local and National
Population health improvement	7FTE have been funded across a variety of roles in the population health and preventative care space related to Child and Youth weight management and Adult weight and diabetes management.	• Improve quality of life and length of life • Improve equity for Maaori and Pacific peoples • Reduce impact of long term disease • Reduce future disease burden on the care sectors	Local
Te Ranga Ora ($3.35m) – co-design and deliver innovative Primary and Community services to support people and whaanau living with Long-Term Conditions ***(Note that implementation of this programme was delayed due to the COVID-19 pandemic)***	Te Ranga Ora will see the development of comprehensive, culturally-capable services and models of care for Māori, Pacific People and people living in quintile 5 with two or more long term conditions. Models will be co-designed and delivered in partnership with local communities and delivered across the Counties Manukau rohe in a phased approach. Supported by CM Health collaboration with MSD and Kāinga Ora.	This will establish five prototype systems of care that bring together multiple organisations (general practice, pharmacy, telehealth providers, social care providers, and NGO) who will work in partnership to enable people in our communities to access a responsive, integrated range of wellness, health and social services close to their homes and their whaanau. People will see their culture and what matters to them reflected in the care and support that they receive.	Local
COVID-19 related impact	Counties Manukau Health continues to drive and support the effort to reduce the impact of, and eradicate COVID-19 from the population. Support continues in the Managed Isolation Facilities, at testing stations and in delivering vaccinations via seconded staff, fixed term appointments and contracts with NGOs. Recovery from the impact in 2020/21 will continue through 2021/22 as the focus returns to delivery of normal business,		Local and Regional

	supported by funding from the Ministry of Health.		
Oral health regional provision changes	As part of the regional planned care steering group, the region is undertaking a co-design equity focused project to understand the barriers for Maaori and Pacific peoples access to determine future service configurations. This may result in more locality focused service provision.	Improve service coverage for Counties Manukau population	Local and Regional

4. Stewardship

This section will outline the DHB's stewardship of its assets, workforce, Information Technology/Information Systems (IT/IS) and other infrastructure needed to deliver planned services.

CM Health commits to working with its Alliance partners and Auckland Regional Public Health Services, within its fiscal and resource capabilities, to promote and deliver services that enhance the effectiveness of prevention activities, and to undertake its functions within regulatory parameters.

4.1 Managing our business

Organisational performance management

In CM Health's role as provider of hospital and specialist services, CM Health has an agreed set of financial and non-financial performance indicators with an established structure for reporting and review. Productivity and quality indicators are reported at operational and clinical management forums and to the Board and related Board committees, i.e. the Hospital Advisory Committee (HAC) and Community and Public Health Advisory Committee (CPHAC) and others.

In 2021/22 CM Health will continue to work regionally to support further improvement against the national System Level Measures and other priorities as described previously in this annual plan.

Funding and financial management

CM Health utilises business and public sector standard practices that ensure best practice financial management at both the macro and micro level. At a macro level there are robust budget, forecasting and reporting processes that link in all levels of management in a structured framework accountable through the Chief Financial Officer to the Chief Executive and Board. Additional financial savings and improvement plans including Every $ Counts and Every Hour Counts and monitoring controls are in place to support the DHB to recover its financial deficit position. At a micro level, procuring and funding of non-government organisation (NGO) provider services requires a commercial approach, including meeting "Government Rules of Sourcing" requirements, to ensure value for money services and financially sustainable NGO providers.

Please refer to the Financial Performance Summary in Section 2.0 of the Statement of Performance Expectations 2021/22 for further information about Counties Manukau DHB's planned financial position for 2021/22 and out years.

Local and regional investment and asset management

In 2016 all DHBs completed a 10-year Long Term Investment Plan (LTIP) as part of the new Treasury Investment Management and Asset Management Performance (IMAP) system for monitoring investments across government. The Northern Region DHBs chose to collaborate and align investment plans and collective priorities.

The first Northern Region Long Term Investment Plan (NRLTIP) was completed and approved by each DHB Board in 2018. The plan details regionally prioritised investments over a 10 to 15-year timeframe within the context of a 25-year horizon. The NRLTIP sets the Northern Region strategic investment path, and supports the Region to deliver optimal health gain for the Northern Region's population within available resources.

The NRLTIP identifies three investment themes for the Northern Region:

- Fixing current facilities to ensure they are fit for purpose. This includes the concepts of asset resilience, renewal and refurbishment
- Future proofing capacity for expected demand. This recognises that there are lead times of 5 to 10 years for some asset developments and that these cannot be developed in crisis
- Accelerating model of care change programmes. This includes enhancing levels of service and transformative change.

The NRLTIP signalled an immediate requirement for a significant lift in the Region's capital expenditure; particularly to address the issues identified against the NRLTIP 'Fix' and 'Future-proof' themes. Significant and urgent investment is needed in the Northern Region to ensure population health needs are met and to ensure the sustainability of existing health services.

The plan was developed under the regional governance structure with contribution from the Region's clinical networks, clinical governance groups and other region-wide work groups; these workgroups included representation from across the continuum of care and from within different health care settings. The NRLTIP Programme Steering Group ensured a collaborative approach to the planning work and, in addition to regional health sector representatives, included local representation from Auckland Council as well as national representation from the Ministry of Health and Treasury.

The NRLTIP investment logic directly reflects the Northern Regional Intervention Logic and Regional Business Objectives to ensure that the investment plans, that shape the capital works to be progressed across the Region, are based on a shared view of the priorities for the Region.

Shared service arrangements and ownership interests

Counties Manukau DHB has a part ownership interest in the Northern Regional Alliance Ltd, healthSource NZ Ltd (formerly healthAlliance NZ Ltd) and NZ Health Innovation Hub Limited Partnership. The DHB does not intend to acquire shares or interests in other companies, trusts or partnerships at this time.

Risk management

Counties Manukau DHB has a formal risk management and reporting system. CM Health is currently reviewing and refining its risk management system, including the internal risk register. The DHB is committed to managing risk in accordance with the process set out in the Australian/New Zealand Joint Standard on Risk Management (AS/NZS ISO 31000:2009).

Quality assurance and improvement

Counties Manukau DHB's approach to improvement science is in line with the New Zealand Triple Aim: improved quality, safety and experience of care, improved health and equity for all populations, and, best value for public health system resources. Contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits.

Work health and safety

Our people are our greatest asset and their being healthy and safe is the foundation from which the DHB can deliver on its strategic goal of achieving health equity for the community it serves. Counties Manukau Health's aim is Haumaru mauriora (a positive H&S culture) so that every person knows what it takes for them to be healthy and safe, and to support their colleagues to be healthy and safe. Each of us is responsible for our own safety and the safety of the people we work with (Haumaru tangata). Our leaders and management commitment to health and safety is evident with a values driven leadership which is enabling of continuous improvement in Haumaru mauriora.

4.2 Building capability

The following sections outline key capabilities and initiatives to support improved capability in 2020/21, across capital and infrastructure investment, information technology and communication systems, workforce and co-operative developments.

4.2.1 Capital and infrastructure development

Regional population health priorities

As part of the work for the NRLTIP, the Northern DHBs established a Regional Public and Population Health Deep Dive Steering Group to clarify the service delivery intentions and the short, medium and long term investment implications for Public and Population Health in the Northern Region, with a particular focus on addressing inequities in access and outcomes.

CM Health will continue to engage with this work to progress population health priorities for the Region.

Regional capital and infrastructure development – Regional Capital Investment Programme[10]

Health Services in the Northern Region are dealing with existing assets (facilities, infrastructure and clinical equipment) in variable condition, considerable growth in demand and a need to develop capability for different care models to improve health equity and outcomes for the population. The 2018 Northern Region Long Term Investment Plan (NRLTIP) and subsequent studies describe the size and nature of the demand for health services and the Region's intended response to ensure future capability to deal with these demands. The NRLTIP is currently being refreshed.

The Regional Capital Investment Group (RCIG) is accountable for overseeing a programme to ensure that the planning, delivery and the on-going management of capital investments will meet the future needs of the population.

Long term objectives

The Regional Capital Investment Group and its three RCIG working sub-groups were established to address the long term goals of a Capital Investment Programme i.e. to deliver and maintain a future investment path for significant health capital investments that:

- Is consistent with the Northern Region long term health planning strategic direction
- Gives effect to national and regional policy
- Adheres to best practices, including business cases, asset management and capital delivery activities supported by processes aligned to good practice investment planning principles

2021/22 Annual Objectives

The objectives for the Regional Capital Investment Programme during 2021/22 are to:

- Oversee work to develop a prioritised capital investment programme that aligns with regional direction and national priorities
- Support capital business case development (including quality assurance and regional endorsements)
- Progress the capital planning and investment process improvements
- Provide oversight and coordination of delivery of the investment programme at a regional level
- Consider any changes to investment strategy following the Northern Region's COVID-19 response

CM Health capital and infrastructure development

In 2017/18 CM Health aligned its long-term district investment plan with the agreed NRLTIP priorities. This requires a balanced district investment portfolio which aligns with regional priorities to manage capacity growth and support whole of system solutions. The pipeline of investment priorities will progress through to business case development.

The 2021/22 fiscal year will include completion and progression of major capital projects already underway (as per Table 2 below) and significant development of business cases to address critical facilities infrastructure risks and service capacity challenges in line with the MOH Budget 2021 funding indications together with the capital intentions submitted to the MOH. Refer to section 2.4.8 for further detail on CM Health's capital investments.

[10] Source: Capital Section Northern Region Service Plan

Table 2

Capital Project – funding approved	Category of project	Planned completion date	Location	Total Project Budget
Scott Building reclad	Remediation	August 2021	Middlemore Hospital	$22.5m
Gastroenterology Procedure room	Expansion	December 2021	Middlemore Hospital	$6.8m
Second Cardiac Cath Lab & Renal Dialysis Unit	Expansion	September 2022	Middlemore Hospital	$16.1m
Radiology department	Relocation	September 2023	Middlemore Hospital	$22m
Neonatal unit	Expansion	October 2021	Middlemore Hospital	$5m
Manukau Health Park (incl. outpatient clinics, Radiology, Renal, Theatres, Breast)	Expansion	Mid-2024	Manukau Super Clinic	$235.9m[11]
Capital Project - business cases in development	**Category of project**	**Planned completion date**	**Location**	**Total Project Budget**
Core Infrastructure – Detailed Business Case	Remediation	August 2021	Middlemore Hospital	$20m
Middlemore – Programme Business Case	Expansion	2021	Middlemore Hospital	To Be Confirmed
Specialised Rehabilitation Centre – Detailed Business Case	Remediation and Expansion	Dec 2021	Manukau Super Clinic	$110m + proceeds from sale of land
Manukau Community Hub (build / lease development) – Single Stage Business Case	Relocation and expansion	July / August 2021	54 Station Rd, Manukau	To Be Confirmed

A review of primary and community services and future investment requirements is progressing with the aim to develop a plan in response to inter-sectorial developments and local population health priorities. This is integral to CM Health being able to deliver its refreshed strategy.

Counties Manukau Health adopted an Environment Sustainability Strategy in 2021 and new facilities are designed based on Green Star principles. For each major facilities development, the early concept design processes that inform business case development includes cost benefit assessment of sustainability options.

Final design is subject to affordability, however the new Acute Mental Health Unit, Tiaho Mai demonstrates some of these features together with the Manukau Health Park Development designed to a Green Star 4 rating.

[11] The CIC letter dated 17 December 2021 has MOH funding of $216.4m in total. The DHB has funded $4m from previous land sale proceeds and the DHB is also funding $15.5m in buying all the major radiology equipment = total $235.9m

4.2.2 Information technology (IT) and communications systems

Digital systems are fundamental to the ability to meet the organisation's purpose and priorities. Our goal is for information to be easily accessible to those who need it, including patients and their whaanau, to support the best decisions, improve the quality and safety of care provided, and improve patient experience across the care continuum. Three to five year plans demonstrate our commitment to increasing digital maturity.

The programme of work is derived directly from the Regional Information Systems Strategic Plan (ISSP) or aligns with the ISSP in principle. All new projects are overseen by the new regional governance structure, established in 2019.

Our strategic direction is a shift to Cloud services, aligning with NZ Digital Health Strategic Framework principle of 'Cloud First'. The shift of the regional data store and dashboard, established to support the COVID-19 response, aligns with the Ministry of Health cloud-based toolset, enabling easy data exchange between northern DHBs and the Ministry.

Implementation of the regional collaborative community care system (RCCC) is now planned to commence in 2021/22. While Counties Manukau Health plans to join in later years (the implementation commences in NDHB), our contribution to design and implementation will be critical. This project is a major enabler of better collaboration and information exchange between community, primary and secondary care.

CM Health will be following WDHB in the implementation of an Outpatient online booking system which will give patients greater control over the timing of their outpatient care. This is a significant step toward easier access to their health services.

Telehealth (telephone and video) appointments enabled us to deliver approximately 25,000 appointments over the COVID lock down period that may otherwise have been cancelled. Patient feedback has been positive and indicates that CM Health should continue to offer telehealth appointment options. Work to sustain and implement telehealth includes building patient choice into booking processes (as outlined above), integration of the video platform with the booking system, establishing community pods for telehealth and development of electronic tools such as Patient Emailer (an in-house built tool), patient questionnaires, eLabs, ePrescribing and eOutcomes.

We plan to implement a secure communications solution to replace the pager system in 2021/22. This system will provide communication for critical 777 emergency responses, as well as clinical and non-clinical task management.

A replacement electronic Whiteboard for the Emergency Department is planned for roll-out in 2021/22. It allows single-click launching of nearly all clinical systems and performance is significantly faster than the current product.

The DHB Maaori and Pacific Health Gain teams require intuitive data explorers to support their goal of reducing inequity of access. We will work with these teams to design specific Qlik Sense dashboards with that purpose in mind.

IT security has matured greatly in the last two years through a significant investment in cyber-security. It is important to continually maintain and strengthen digital security in an increasingly interconnected world. Subject to funding, the region aims to build on investment to date, such as foundational security incident event management (SIEM) tools and resources, to further embed a cyber-security controls framework that complies with HISF/NZISM and Ministry of Health digital service requirements.

4.2.3 Workforce

Provide training placements and support transition to practice for eligible health workforce graduates and employees

Provide training placements and support transition to practice for eligible health workforce graduates and employees

The strong relationships with our strategic tertiary partners will continue in 2021/22 through regular liaison and forums and expansion to additional tertiary partners. As with 2020/21 focus remains on increasing the number of student placements CM Health is able to offer tertiary providers, through exploring different models of placements

and developing inter-professional education opportunities. There is intent to accommodate student placements for students who live in the local area and Maaori and Pasifika students.

Nurse Entry to Practice (NETP) graduates within the Counties Manukau region are supported with the CM Health NETP programme, with intake numbers anticipated to increase in 2021/22. Nursing, occupational therapy and social work graduates are supported through the New Entry to Specialist Practice (NESP) (Mental Health) programme, with an increase likely in graduate numbers. Scoping the capacity of the NETP and NESP programmes to support additional students will continue in 2021/22.

An allied health new graduate supervision group will continue to be offered throughout 2021/22, this is an inter-professional group open to physiotherapy, occupational therapy, social work, dietetic and speech and language therapy graduates in their first year of employment.

CM Health continues to offer trainee places to the following allied health, scientific and technical professions; anaesthetic technicians, cardiopulmonary technicians, physiology technicians, ultrasonographers, and clinical psychology internships through funding from the Health Workforce Directorate, Ministry of Health. There is continued liaison with the Northern Regional Alliance on regional workforce strategies.

CM Health is working with Manukau Institute of Technology to investigate the provision of health care assistant student placements earlier in their training programme.

Form alliances with training bodies to ensure that CM Health has a well trained workforce

CM Health is represented on several professional programmes advisory boards with tertiary education institutes, e.g. physiotherapy at Auckland University of Technology, and nursing at Manukau Institute of Technology, Auckland University of Technology and the University of Auckland. These offer an opportunity to influence the content and delivery of these programmes with the intention of training programmes producing health graduates who are fit for purpose. There is also representation on professional boards including Occupational Therapy New Zealand Aotearoa, Nursing Council of New Zealand, and the Medical Sciences Council of New Zealand.

An intrinsic part of CM Health is the Ko Awatea Education Centre. It is purpose-built to provide an open, social learning space, with lecture theatres, breakout rooms, and a variety of teaching spaces. The Centre was built in 2011 as a joint venture project with the Auckland University of Technology, Manukau Institute of Technology and the University of Auckland, and is a contemporary building with modern capabilities to match. The Centre has a Customer Support and Technology Help office providing service and support to the Centre and its users. In addition to providing a training venue for future allied health, medical, and nursing workforce, the centre also hosts a large number of CM Health staff forums and events and local, national and international visitors.

Co-operative developments

There is a need to continue to build on the strong relationships with our strategic tertiary partners, and to expand linkages with additional tertiary providers. As with 2020/21 focus remains on increasing the number of student placements CM Health is able to offer to tertiary providers, through exploring the expansion of the Dedicated Education Unit (DEU). This scoping is being undertaken with involvement from Manukau Institute of Technology, the University of Auckland and Auckland University of Technology.

There has been development in the graduate entry nursing Masters programmes at both Auckland University of Technology and the University of Auckland. CM Health has been linked in with the development of these innovative programmes, with the first students from both programmes undertaking student placements at CM Health in 2019/20. CM Health continues to collaborate with the University of Auckland in relation to postgraduate research supporting Bachelor of Nursing (Honours) and PhD intern programmes

4.3 Workforce

Please refer to the Workforce priority on page 65 for details of planned workforce activities for 2021/22.

4.4 Information technology

Please refer to the IT priority page 66 for details of planned IT activities for 2021/22.

5. Performance measures

The health and disability system has been asked to focus on the following priorities:

- Improving child wellbeing
- Improving mental wellbeing
- Improving wellbeing through prevention.
- Better population health outcomes supported by strong and equitable public health and disability system
- Better population health outcomes supported by primary health care.

The DHB monitoring framework and accountability measures have been updated for 2021/22 to provide a line of sight between DHB activity and the health system priorities that will support delivery of the Government's priority goals for New Zealand and the health system vision and outcomes, within a system that has a foundation of financial, clinical and service sustainability and strong governance.

2021/22 Performance Measures

Performance measure		Expectation		
CW01	Children caries free at 5 years of age	Year 1	49%	
		Year 2	49%	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	<0.74	
		Year 2	<0.74	
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled (≥ 95 percent of pre-school children (aged 0-4 years of age) will be enrolled in the COHS)	Year 1	>=95%
			Year 2	>=95%
		Children (0-12) not examined according to planned recall (≤ 10 percent of pre-school and primary school children enrolled with the COHS will be overdue for their scheduled examinations with the COHS.)	Year 1	<=10%
			Year 2	<=10%
CW04	Utilisation of DHB funded dental services by adolescents from school Year 9 up to and including 17 years	Year 1	>=85%	
		Year 2	>=85%	
CW05	Immunisation coverage at eight months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight month olds fully immunised.		
		95% of five year olds fully immunised.		
		75% of boys and girls fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General Practice	The DHB has reached the "Total population" target for children enrolled with a general practice by 6 weeks of age (55%) and by 3 months of age (85%) and has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for the		

Performance measure		Expectation		
		Maaori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Increased immunisation at two years	95% of two year olds have completed age-appropriate immunisations due between birth and two years.		
CW09	Better help for smokers to quit (maternity)	90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.		
CW12	Youth mental health initiatives	Focus area 1 (Youth SLAT): Provide reports as required		
		Focus area 2 (School Based Health Services): Provide reports as required		
		Focus area 3: (Youth Primary Mental Health services) refer MH04		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Maaori, other & total	Total	3.9%
			Maaori	5.8%
			Pacific	2.5%
			Other	3.4%
		Age (20-64) Maaori, other & total	Total	3.9%
			Maaori	9.0%
			Pacific	4.0%
			Other	3.1%
		Age (65+) Maaori, other &total	Total	2.2%
			Maaori	3.0%
			Pacific	2.5%
			Other	2.1%
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.		
		95% of audited files meet accepted good practice.		
MH03	Shorter waits for mental health services for under 25-year olds	Provide reports as specified.		
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified		

Performance measure		Expectation		
MH05	Reduce the rate of Maaori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Maaori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.		
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.		
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care	Provide reports as specified		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
PV02	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.		
SS01	Faster cancer treatment – 31 day indicator	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS03	Ensuring delivery of Service Coverage	Provide reports as specified.		
SS04	Delivery of actions to improve Wrap Around Services for Older People	Provide reports as specified.		
SS05	Ambulatory sensitive hospitalisations (ASH adult)	Total 45-64 years	4,600/100,000 population	
SS07	Planned Care Measures	Planned Care Measure 1: Planned Care Interventions		TBC inpatient surgical discharges TBC minor procedures TBC non-surgical interventions
SS07	Planned Care Measures	Planned Care Measure 2: Elective Service Patient Flow Indicators	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less).
			ESPI 2	0% - no patients are waiting over four months for FSA.
			ESPI 3	0% - zero patients in Active Review with a

Performance measure	Expectation		
			priority score above the actual Treatment Threshold (aTT).
		ESPI 5	0% - zero patients are waiting over 120 days for treatment.
		ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised priority tool.
	Planned Care Measure 3: Diagnostics waiting time	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).
		Computed Tomography (CT)	95% of patients with accepted referrals for CT scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
		Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans will receive their scan, and the scan results are reported, within 6 weeks (42 days).
	Planned Care Measure 4: Ophthalmology Follow-up Waiting Times	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
	Planned Care Measure 6: Acute Readmissions	0-28 days	< or equal to 10.7% (TBC)
	Planned Care Measure 7: Did Not Attend Rates (DNA) for First Specialist Assessment (FSA) by Ethnicity (Developmental)	Provide reports as specified.	

Performance measure		Expectation		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	To be confirmed by MOH
			New NHI registration in error (duplication)	Group A >2% to < or equal to 4%
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures	Greater than or equal to 90% and less than 95%
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5 %
			Assessment of data reported to the NMDS	Greater than or equal to 85% and less than 95%
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Provide reports as specified
SS10	Shorter stays in Emergency Departments	95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		

Performance measure		Expectation	
SS12	Engagement and obligations as a Treaty partner	Reports provided and obligations met as specified	
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions, milestones and measures to: Support people with LTC to self-manage and build health literacy.
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity
		Focus Area 3: Cardiovascular health	Provide reports as specified.
		Focus Area 4: Acute heart service	Indicator 1: Door to cath - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram**.**
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and Indicator 2b: ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. have had an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - Aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes) - ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), - Beta-blocker if LVEF<40% (5-classes).

Performance measure		Expectation	
			- *An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.
			Indicator 5: Device Registry Completion - ≥99% of patients who have a pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within 2 months of this procedure. Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within 2 months of the procedure.
		Focus Area 5: Stroke services	Indicator 1 ASU: 80% of acute stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway within 24 hours of their presentation to hospital"
			Indicator 2 Reperfusion Thrombolysis/ Stroke Clot Retrieval: 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)

Performance measure		Expectation	
			Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.	
		70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.	
		95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 working days of their FIT result being recorded in the NBSP IT system.	
SS17	Delivery of Whaanau ora	Appropriate progress identified in all areas of the measure deliverable.	
PH01	Delivery of actions to improve SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90 percent.	
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Maaori population of 95 percent or above	
PH04	Primary health care :Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	
Annual plan actions – status update reports		Provide reports as specified	

Appendix 1: 2020/21 Statement of Performance Expectations

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Statement of Performance Expectations including Financial Performance (for tabling as SPE)

1.1 Statement of Performance Expectations

Four 'output classes' are used by all District Health Boards (DHBs) to reflect the nature of services they fund and provide. These output classes reflect the continuum of care and are: prevention services, early detection and management services, intensive assessment and treatment services and rehabilitation and support services.

This SPE is organised by output class and describes the services CM Health plans, funds, provides and promotes within each output class. Each output class includes a number of key measures of output and impact that are significant to CM Health's achievement of key strategic objectives, and that provide a fair representation of the DHB's performance. Note that these measures are not intended to be a comprehensive outline of all performance measurement activity within the organisation.

In presenting CM Health's performance story, it is important to present a mix of measures that indicate performance in a range of different ways. For example, for some services the most important measure of performance will be how much of it is delivered (volume), whereas for other services the best measure of performance may be how quickly that service was provided (timeliness).

This SPE therefore includes a spread of indicators that cover the following areas of performance: Volume (V), Timeliness (T), Quality (Q) and Coverage (C). Each of the performance measures has a reference classification to assist with quick categorisation.

Reference Key			
SLM	System Level Measure	**V**	Volume
SLMc	System Level Measure Regional Contributory Measure as included in the 2021/22 Auckland, Waitemata & Counties Manukau Health Alliances System Level Measures Improvement Plan (the 2021/22 Metro Auckland SLM Improvement Plan)	**T**	Timeliness
		Q	Quality
		C	Coverage

1.2 Note on the baselines and targets contained in the Statement of Performance Expectations

Unless otherwise indicated, CM Health's actual performance as at Quarter 4 2019/20 year has been used as the baseline measurement for CM Health's Statement of Performance Expectations. CM Health is unable to use Quarter 4 2020/21 performance as the baseline as this data will only be available after the SPE publication date.

Footnotes have been used throughout the document to identify those measures for which a different baseline has been used. This includes those measures reported in Quarters 1 and 3 only in which case the Quarter 3 2019/20 performance has been used as the baseline, and for Metro Auckland System Level Measures Improvement (SLM) Plan baselines.

Many of CM Health's performance targets are set by the Ministry of Health or through the Metro Auckland SLM Improvement Plan and represent the minimum level of performance that CM Health is aiming to achieve. In some cases, CM Health may have achieved results in Quarter 4 2019/20 that are higher than the stated target for 2021/22. This does not indicate that CM Health intends to reduce the level of performance in 2021/22 but does show that CM Health exceeded the minimum level of performance in 2019/20.

1.3 Prevention Services

Preventative services are publicly funded services that protect and promote health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population as distinct from treatment services which repair/support health and disability dysfunction.

Preventative services address individual behaviours by targeting population wide physical and social environments to influence health and wellbeing. They include health promotion to ensure that illness is prevented and unequal outcomes are reduced; statutorily mandated health protection services to protect the public from toxic environmental risk and communicable diseases; and, population health protection services such as immunisation and screening services. On a continuum of care these services are public wide preventative services.

Preventative services are aligned with the DHB's **Healthy Communities** strategic objective that is focused on primary (ill-health) prevention across the life course.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Health Promotion and Education Services				
Percentage of PHO enrolled patients who smoke who have been offered help to quit smoking by a health care practitioner in the last 15 months	Total	88%[12]	90%	C
	Maaori	88%		
	Pacific	90%		
	Asian	86%		
Percentage of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer who are offered brief advice and support to quit smoking	Total	94%	90%	C
	Maaori	94%		
Percentage of babies living in smokefree homes at six weeks postnatal	Total	44%[13]	45.6%[14]	SLMc
	Maaori	22%		
	Pacific	35%		
Percentage of babies fully or exclusively breastfed at 3 months	Total	49%	70%	Q
	Maaori	39%		
	Pacific	45%		
Percentage of children identified as obese in the B4SC programme who are offered a referral to a registered health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions	Total	100%	95%	Q
	Maaori	100%		
	Pacific	100%		
	Other	100%		
Number of eligible adult service users engaged in the Green Prescription programme each year	Total	2,921[15]	4,000	V

[12] Baseline was impacted by COVID-19.
[13] Baseline for 2019/20 is from the period January 2020 – June 2020.
[14] The target represents a 2% relative increase from baseline as per the 2021/22 Metro Auckland SLM Improvement Plan.
[15] Data reported six-monthly. Baseline as at March 2019 (Q3).

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Immunisation Services				
Proportion of 8 month olds who have their primary course of immunisation (six weeks, three months and five months immunisation events) on time	Total	92%	95%	C
	Maaori	84%		
	Pacific	92%		
	Asian	98%		
Proportion of eligible boys and girls fully immunised with HPV vaccine	Total	60%[16]	75%	C
	Maaori	57%		
	Pacific	59%		
	Asian	73%		
Percentage of people aged over 65 years who have had their flu vaccinations	Total	53%[17]	75%	C
	Maaori	43%		
	Pacific	65%		
	Asian	54%		
Health Screening				
Proportion of women aged 50-69 years who have had a breast screen in the last 24 months	Total	70%[18]	70%	C
	Maaori	65%		
	Pacific	81%		
	Other	69%		
Proportion of women aged 25-69 years who have had a cervical smear in the last three years	Total	65%	80%	C
	Maaori	56%		
	Pacific	65%		
	Asian	61%		
	Other	73%		
Percentage of four year olds receiving a B4 School Check	Total	87%	90%	C
	Maaori	82%		
	Pacific	84%		
	Other	91%		

[16] Results are reported annually in Q4 of each year. 2019/20 baseline are for the period 1 July 2019 to 30 June 2020.
[17] 2019/20 results are for the period 1 March 2019 to 30 September 2019.
[18] Baseline is as at Q3 – two years ending 31 March 2020, consistent to MOH Q4 reporting requirements.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Percentage of year 9 students in decile 1-4 high schools alternative education and teen parent unit facilities provided with a HEADSSS[19] assessment	Total	93%[20]	95%	C
	Maaori	96%		
	Pacific	95%		
	Asian	82%		

1.4 Early Detection and Management Services

Early detection and management services are delivered by a range of health and allied health professionals in various private, not-for-profit and government service settings. Include general practice, community and Maaori health services, Pharmacist services, Community Pharmaceuticals (the Schedule) and child and adolescent oral health and dental services.

These services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the DHB.

On a continuum of care these services are preventative and treatment services focused on individuals and smaller groups of individuals. Early detection and management services are aligned with the DHB's **Healthy Services** and **Healthy People, Whaanau and Families** strategic objectives which focus on making services more responsive and easier to access and providing support for people to self-manage at home.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Primary Health Care Services				
Percentage of population enrolled in a PHO	Total	98%	90%	C
	Maaori	92%		
	Pacific	117%[21]		
	Asian	95%		
Percentage of newborns enrolled in general practice by 3 months	Total	90%[22]	85%	C
	Maaori	69%		
	Pacific	86%		
	Other	102%		
Amenable mortality rate per 100,000 population[23]	Total	99.8[24]	98.1%[25]	SLM Q

[19] This is an interview based assessment tool for adolescents about Home Education/Employment Activities Drugs Sexuality Suicide
[20] Baselines are for the calendar year 1 January – 31 December 2020.
[21] The Census data is used for population denominators. As the Census has historically undercounted the Pacific population, the percentage is greater than 100%.
[22] Baselines are as at June 2020 for the full financial year.
[23] Amenable mortality rate per 100,000 population (age standardised), 0-74 year olds, using NZ estimated resident population as at June 30 2016.
[24] Result is at 2017, this is a draft result at time of publishing.
[25] For the total population this measure targets a 6% relative reduction from the 2013 baseline by 30 June 2022, as per the 2021/22 Metro Auckland SLM Improvement Plan. The 2021/22 Metro Auckland SLM Improvement Plan also includes a separate target for Maaori and Pacific peoples of a 2% relative reduction by 30 June 2022.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Percentage of eligible population receiving CVD risk assessment in the last 5 years	Total	90%	90%	C
	Maaori	87%		
	Pacific	89%		
	Other	91%		
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)[26] and no inequity	Total	52%	60%	Q
	Maaori	43%		
	Pacific	44%		
	Other	62%		
Percentage of patients with CVD risk >20% on dual therapy (dispensed)	Total	53%	70%[27]	Q
	Maaori	52%	70%	
	Pacific	57%	70%	
	Asian	51%	70%	
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)	Total	58%	70%	SLMc Q
	Maaori	53%	70%	
	Pacific	63%	70%	
	Asian	62%	70%	
Oral Health Services				
Proportion of children under 5 years enrolled in DHB-funded community oral health services	Total	89%	≥95%	SLMc C
	Maaori	72%		
	Pacific	91%		
	Asian	N/A[28]		
	Other	96%		
Percentage of enrolled children caries free at age 5 years	Total	43%	49%[29]	Q
	Maaori	38%		
	Pacific	28%		
	Other	57%		
	Total	0.82		Q

[26] Note that CM Health currently uses the PHO DCIP cohort based on the population aged 15-74 years enrolled with Counties Manukau practices as the denominator for this measure. Work is currently underway to mature and refine HbA1c reporting in CM Health.
[27] 2019/20 SLM Improvement plan targeted a 5% relative increase from baseline for this measure, however due to persistent inequities in CVD management for Maaori, CM Health has chosen to adopt the Metro Auckland Clinical Governance Forum target of 70% for all ethnic groups.
[28] The Asian data was not available in the Ministry of Health data set provided for Q3 19/20.
[29] The 2020/21 Ministry of Health target for the percentage of children caries free at age 5 (49%) is lower than the 2019/20 target (51%). Awaiting confirmation from MoH

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Mean DMFT (Decayed Missing or Filled Teeth Score for Year 8 Children (12/13 years)	Maaori	0.96	0.74[30]	
	Pacific	1.28		
	Other	0.62		
Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Total	71%	≥85%	C
Diagnostics				
Proportion patients with accepted referrals for CT and MRI scans who receive their scan within 6 weeks	CT	63%	95%	T
	MRI	53%	90%	T
Proportion of patients accepted for urgent diagnostic colonoscopy who receive the procedure within 2 weeks (14 days)	Total	100%[31]	90%	T
Proportion of patients accepted as non-urgent diagnostic colonoscopy who receive their procedure within 6 weeks (42 days)	Total	67%	70%	T
Ambulatory Sensitive Hospitalisations				
Ambulatory sensitive hospitalisation (ASH) rate in children aged 0-4 years per 100,000 population	Total	5,324[32]	6,062	SLM Q
	Maaori	5,134	5,421	
	Pacific	8,773	10,440	
Sudden Unexpected Death of an Infant (SUDI)				
SUDI deaths per 1,000 live births	Total	1.18[33]	<0.1[34]	Q
	Maaori	2.40		
Pharmacy				
Number of prescription items subsidised	Total	8,313,812[35]	N/A[36]	V

1.5 Intensive Assessment and Treatment Services

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers using public funds. These services are usually integrated into facilities that enable co-location of clinical expertise and specialized equipment such as a hospital. These services are generally complex and are provided by health care professionals that work closely together.

[30] The 2020/21 Ministry of Health target for mean DMFT score for Year 8 children (0.74) is lower than the 19/20 target (0.75). Awaiting confirmation from MoH
[31] Actual baseline for P1 within 14 days is 99.66% and thus rounded up to 100%.
[32] Data is year to June 2020.
[33] 2019/20 Result date source: This result is unavailable as relies on published data. The most recent published data report is from the Child and Youth Mortality Review Committee: 14th data report 2013-2017.
[34] The Ministry of Health expects DHBs to work toward achieving the target of <0.1 per live births by 2025.
[35] Volume is as at 30 June 2020 for a 12-month rolling period.
[36] Measure is demand driven – not appropriate to set target.

They include:

- Ambulatory services (including outpatient, district nursing and day services) across the range of secondary preventive, diagnostic, therapeutic, and rehabilitative services
- Inpatient services (acute and elective streams) including diagnostic, therapeutic and rehabilitative services
- Emergency Department services including triage, diagnostic, therapeutic and disposition services

On a continuum of care these services are at the complex end of treatment services and focussed on individuals. Intensive assessment and treatment services are aligned with the DHB's **Healthy Services** strategic objective that is focused on excellent, collaborative, high quality and safe health services.

Performance Measure			Baseline 2019/20	Target 2021/22	Notes
Mental Health[37]					
Percentage of population who access mental health services	Age 0-19 years	Total	3.99%	3.9%	C
		Maaori	5.8%	5.8%	
		Pacific	N/A	2.5%[38]	
		Other	N/A	3.4%[39]	
	Age 20-64 years	Total	4.02%	3.9%	
		Maaori	9.79%	9.0%	
		Pacific	N/A	4.0%[40]	
		Other	N/A	3.1%[41]	
	Age 65+ years	Total	2.21%	2.2%	
		Maaori	3.0%	3.0%	
		Pacific	N/A	2.5%[42]	
		Other	N/A	2.1%[43]	
Percentage of discharges from CM Health MHA inpatient units for which community services contact was recorded within 7 days of discharge[44]		Total	76%	95%	T
Reduce the rate of Maaori per 100,000 population under the Mental Health Act: section 29 community treatment orders		Total	403	N/A	T
		Maaori	321	301	
Elective Services					
Planned Care Measure 1: Planned Care Interventions	Inpatient treatments		18,248	20,185	V
	Minor interventions		13,186	10,611	

[37] Proportion of people referred for non-urgent mental health or addiction services who are seen within 3 weeks and 8 weeks for 0-19 years has been removed from this plan as it will be measured within the Health System Indicators Framework
[38] Pacific target added in 2021/22
[39] Other target was added in 2020/21
[40] Pacific target added in 2021/22
[41] Other target was added in 2020/21
[42] Pacific target added in 2021/22
[43] Other target was added in 2020/21
[44] Source: www.mhakpi.health.nz. CM Health is in the process of developing a suite of mental health and wellbeing measures. As these measures are being developed, the timeliness of post-acute discharge community care contact being made provides a reasonable indication of how our MHA inpatient and community services are performing.

Performance Measure			Baseline 2019/20	Target 2021/22	Notes
	Non-surgical alternatives		1	326	
Acute Services					
Readmissions – acute readmissions to hospital		0-3 days	2.4%	≤2.3%	V
		0-28 days	10.8%	≤10.7%	
Inpatient average length of stay		Acute LOS	2.94 days	2.3 days	Q
		Elective LOS	2.07 days	1.50 days	
Proportion of patients admitted, discharged or transferred from the Emergency Department within six hours			83%[45]	95%	T
Cancer Services					
Proportion of patients who receive their first treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks		Total	85%[46]	90%	T
Cardiac Services					
Percentage of high-risk patients who receive an angiogram within 3 days of admission		Total	69%[47]	>70%	T
		Maaori	66%		
		Pacific	62%		
		Other	72%		
Stroke Services					
Percentage of potentially eligible stroke patients thrombolysed			12.6%	10%	C
Quality and patient safety					
Percentage of admissions with hospital acquired complication			2.8%[48]	<2.3%	Q
Rate of falls with major harm per 1000 bed days			0.08[49]	<0.04	Q
Percentage of inpatients (aged 75+) assessed for risk of falling			94%[50]	90%	Q
Rate of S. aureus bacteraemia (SAB) per 1000 bed days			0.13[51]	<0.09	Q
Compliance with good hand hygiene practice			86%[52]	80%[53]	Q
System Level Measures					
Acute hospital bed days per capita (standardised) [54]		Maaori	640[55]	686	SLM

[45] 2019/20 baseline is for the full financial year. Q4 2019/20 result for the three-month period was 93%.
[46] 2019/20 baseline is for the full financial year. Q4 19/20 result for the three-month period was 87%.
[47] 2019/20 baseline is for the full financial year Q4 2019/20 result for the three-month period was Total: 73% Maaori: 62% Pacific: 62% Other: 80%.
[48] Baseline is from July 2019 to June 2020.
[49] Baseline is from July 2019 to June 2020.
[50] Baseline is from July 2019 to June 2020
[51] Baseline is from July 2019 to June 2020.
[52] Compliance rate for 1 March to June 2020.
[53] Currently, the national hand hygiene compliance target for DHBs is set at 80 percent by HQSC. CM Health achieved the target as at June 2019 with 88% compliance.
[54] In line with the equity focus of the 2021/22 planning guidance, the targets for reducing bed days in the 2021/22 SLM Plan are for Māori and Pacific populations specifically.
[55] Baseline is as at June 2020.

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
	Pacific	680	718	Q

1.6 Rehabilitation and Support Services

Rehabilitation and support services are delivered following a 'needs assessment' process and coordination input by Needs Assessment and Service Coordination (NASC) Services for a range of services including day care, home-based support services and residential care services. Rehabilitation services are provided by specialised multidisciplinary teams overseen by a Geriatrician and/or Rehabilitation Medicine Specialist Medical Officer. On a continuum of care these services will provide support for individuals. Rehabilitation and support services are aligned to the DHB's **Healthy People, Whaanau and Families** strategic objective which is focused on supporting people, whaanau and families to stay well and live independently in the community

Performance Measure		Baseline 2019/20	Target 2021/22	Notes
Age Related Residential Care (ARRC)				
Percentage of people in ARRC who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of previous assessment		92%[56]	95%	T
Percentage of LTCF clients admitted to an aged residential care facility who had been assessed using an interRAI Home Care assessment tool in the six (6) months prior to that first LTCF assessment		92%[57]	90%	T
Home Based and Community Support				
Percentage of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan.		97%[58]	95%	Q
Assessment, Treatment and Rehabilitation Services				
Number of older people that have received in-home strength and balance retraining services	Aged 65+	823	1,118	V
Number of older people that have received community / group strength and balance retraining services	Aged 65+	659[59]	1,400	V
Total number of offerings per class for community group strength and balance retraining services	Aged 65+	2,120	2,325 places	
Number of older people that have been seen by the Fracture Liaison Service (FLS) or similar fracture prevention service	Aged 50-74	520	600	V
	Aged 75-84	355	300	
	Aged 85+	331	300	
Palliative care[60]				

[56] 2019/20 baseline is for the full financial year. Q4 2019/20 result was 92%.
[57] 2019/20 baseline is for the full financial year. Q4 2019/20 result was 89%.
[58] This measure is reported a quarter in arrears. The baseline for the financial year up to and including Q3 19/20. Q4 cannot be reported as, between late March and 26 July, providers were funded a fixed fortnightly amount and providers ceased fee for service claiming through MOH Sector Operations.
[59] 659 new and unique attendees.
[60] The following measures are part of the regional Better Palliative Care Outcomes Service which has been implemented and delivered in the Auckland Region from 2017/18. This service implements a system-based approach to enable six hospices across the Auckland region to work

Performance Measure	Baseline 2019/20	Target 2021/22	Notes
Number of Palliative Pathway Activations (PPAs) in Counties Manukau	194	552	V
Number of Hospice Proactive Advisory conversations between the hospice service, primary care and ARRC health professionals	190	552	V

1.7 Output classes

The following tables provide a prospective summary of revenue and expenses by Output Class and should be viewed with reference to the financial narrative in section 2.0. These are a work in progress.

Prevention

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**49,125**	**50,532**	**51,938**	**52,137**
Personnel costs	21,178	21,601	22,033	21,601
Outsourced Services	1,921	1,960	1,999	1,960
Clinical Supplies	5,907	6,025	6,146	6,025
Infrastructure & Non-Clinical Supplies	1,109	1,132	1,154	1,132
Other	19,010	19,814	20,606	21,419
Total Expenditures	**49,125**	**50,532**	**51,938**	**52,137**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Early Detection & Management

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**304,351**	**317,263**	**329,900**	**342,810**
Personnel costs	813	829	846	829
Outsourced Services	74	75	77	75
Clinical Supplies	227	231	236	231
Infrastructure & Non-Clinical Supplies	43	43	44	43
Other	303,194	316,085	328,697	341,632
Total Expenditures	**304,351**	**317,263**	**329,900**	**342,810**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

together with the Metro Auckland DHBs, Age Related Residential Care (ARRC) and primary care stakeholders to achieve better palliative care outcomes for those with a terminal illness and their families regardless of where in the system palliative care is provided.

Intensive Assessment & Treatment

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**1,541,974**	**1,647,661**	**1,732,368**	**1,823,249**
Personnel costs	817,112	872,975	938,212	993,800
Outsourced Services	114,792	133,772	110,634	109,547
Clinical Supplies	140,626	150,785	157,357	167,724
Infrastructure & Non-Clinical Supplies	143,440	149,847	163,625	182,524
Other	375,727	395,088	412,712	431,134
Total Expenditures	**1,591,696**	**1,702,467**	**1,782,540**	**1,884,729**
Net Deficit	**(49,722)**	**(54,806)**	**(50,172)**	**(61,480)**

Rehabilitation & Support

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**215,701**	**226,344**	**237,742**	**249,172**
Personnel costs	11,893	12,131	12,374	12,131
Outsourced Services	1,079	1,101	1,123	1,101
Clinical Supplies	3,317	3,384	3,451	3,384
Infrastructure & Non-Clinical Supplies	623	635	648	635
Other	198,789	209,093	220,146	231,921
Total Expenditures	**215,701**	**226,344**	**237,742**	**249,172**
Net Surplus (Deficit)	**-**	**-**	**-**	**-**

Total

	2021/22 Plan $000	2022/23 Plan $000	2023/24 Plan $000	2024/25 Plan $000
Total Revenue	**2,111,151**	**2,241,800**	**2,351,948**	**2,467,368**
Personnel costs	850,996	907,536	973,465	1,028,361
Outsourced Services	117,866	136,908	113,833	112,683
Clinical Supplies	150,077	160,425	167,190	177,364
Infrastructure & Non-Clinical Supplies	145,215	151,657	165,471	184,334
Other	896,720	940,080	982,161	1,026,106
Total Expenditures	**2,160,873**	**2,296,606**	**2,402,120**	**2,528,848**
Net Deficit	**(49,722)**	**(54,806)**	**(50,172)**	**(61,480)**

2. Financial performance

2.1 Introduction

CM Health remains fully committed to achieving the Government's priorities, despite the increasing fiscal constraints the health sector is facing. Capacity pressures associated with unprecedented growth in the demand for clinical services have placed significant strain on current budgets and staff across the system. Even when allowing for implementation of change and innovations to increase efficiency, projected increases in demand across the health system in the coming years will be difficult to accommodate whilst maintaining fiscal sustainability. We also continue to accommodate cost pressures with respect to current Multi Employer Collective Agreements (MECA). Sector pay restraint assumptions have been incorporated in FY22 and outer year forecasts.

While CM Health is pleased to have received an additional $108m Population Based Funding in the 2021/22 year, an estimated 7,000 of CM Health's population remains unfunded, amounting to a funding shortfall of ~$19.8m. In the 2021/22 year, of the $120m million of additional funding received (PBFF and other funding streams i.e. ACC, MoH MECA, planned care and CFA agreements outside PBFF), $64m (59%) of new funding is committed to price increases, $62.2m committed to volume or demand driven growth in mental health, primary and community services and critical hospital capacity. This essential cost growth cannot be adequately funded by new revenue and will need to be met by an ambitious savings target of $23.5m.

The impact of the DHB's response to COVID-19 through FY 20 and 21 has seen continued deployment of a significant number of DHB staff away from normal roles. The ongoing nature and urgency of this work has taken its impact on the delivery of the DHB's strategic programmes to achieve best value from the health system, notably the Every $ Counts (E$C) sustainability programme. This has resulted in a higher underlying cost structure carried forward into the FY22 year. In a deliberate strategy to achieve full value from resources already invested, services have been asked to absorb population growth where possible, limiting new capacity to those areas with highest clinical risk.

The current plan reflects a "standing still" underlying deficit of $29.7m (An additional provision of $20m is added to this recognising ongoing cost of compliance with the Holiday's Act). This plan represents best the attempt to prioritise across "short, medium and long term (transformational)" investment to align with our strategic priorities. The previous three budgets (FY 2018/19 - 2020/21) have taken a risk management approach to ensure that critical clinical risks are managed through limited investment in additional clinical capacity and initiatives to help manage demand growth. This has required considered trade-offs in what was chosen to be prioritised in the budgets. The proposed "standing still" budget position for 2021/22 continues to take this approach to ensure that ground is not lost on the improvements we have made in addressing clinical demand; reducing the 2021/22 budget further than the $29.7m deficit figure would be difficult to achieve without compromising our position with regards to maintaining clinical capacity to meet demand growth, and maintaining current thresholds for, and access to, treatment (i.e. "going backwards").

A "standing still" budget does allow for a level of critical risk reduction and growth in capacity to address acute demand which is now crowding out elective and planned care. Investment in the Board and organisational priority areas of equity and population health are less than desired.

CM Health acknowledges the expectation from the MOH to work towards an underlying breakeven position. The Board and Executive team, together with the Mana Whenua Board, will continue to consider trade off decisions to balance expectations set by the Minister of Health against its obligations to balance value, risk, equity and sustainability on behalf of the community it serves.

2.2 Forecast financial statements

2.2.1 Summary by funding arm

Net Result	2019/20 Audited Actual	2020/21 Unaudited Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$ 000	$ 000	$ 000	$ 000	$ 000	$ 000
Provider	(110,903)	(125,041)	(36,944)	(52,321)	(64,147)	(93,476)
Governance	(2,064)	(4,304)	(456)	(281)	976	1,674
Funder	33,296	85,519	(12,323)	(2,204)	12,999	30,322
Eliminations	-	-	0	-	-	-
Operating Deficit	**(79,671)**	**(43,826)**	**(49,722)**	**(54,806)**	**(50,172)**	**(61,480)**
Other Comprehensive Income	-	86,228	-	-	-	-
(Deficit) / Surplus	**(79,671)**	**42,402**	**(49,722)**	**(54,806)**	**(50,172)**	**(61,480)**

Note: A funding increase assumption of $108m has been top sliced for Mental Health Ring fence and Inter District Flows. The residual balance will be allocated to the Provider based on volumes, with the remainder allocated to Governance and Funder based on proportionate net surplus (deficit). To be updated after funding envelope.

2.2.2 Statement of comprehensive income

Net Result	2019/20 Audited Actual	2020/21 Unaudited Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$ 000	$ 000	$ 000	$ 000	$ 000
Revenue						
Ministry of Health	1,726,278	1,920,035	1,938,928	2,063,180	2,167,100	2,276,067
Other Government	38,478	49,338	49,243	50,656	51,809	53,153
Other	41,817	41,516	44,395	45,698	46,753	47,826
Inter DHB and Internal	83,049	66,973	78,585	82,266	86,286	90,322
Total Revenue	**1,889,622**	**2,077,862**	**2,111,151**	**2,241,800**	**2,351,948**	**2,467,368**
Expenses						
Personnel	765,151	821,131	850,996	907,536	973,465	1,028,361
Outsourced	107,647	123,156	117,866	136,908	113,833	112,683
Clinical Support	131,630	143,971	139,217	148,635	152,971	158,295
Infrastructure	86,641	88,130	86,628	89,077	92,003	93,932
Personal Health	554,227	587,290	626,761	656,882	684,764	713,692
Mental Health	68,928	75,996	80,897	84,310	87,839	91,473
Disability Support	152,542	158,810	178,493	187,886	198,111	209,037
Public Health	25,915	54,338	7,578	7,888	8,207	8,535
Maaori	2,826	2,909	2,991	3,114	3,240	3,369
Operating Costs	**1,895,507**	**2,055,731**	**2,091,426**	**2,222,236**	**2,314,433**	**2,419,377**
Operating Surplus / (Deficit)	**(5,885)**	**22,131**	**19,725**	**19,564**	**37,515**	**47,991**
Depreciation	40,136	40,872	45,695	49,066	57,545	71,908
Capital Charge	33,625	24,986	23,511	24,975	29,827	37,263
Interest	25	99	242	329	315	300
Net Deficit	**(79,671)**	**(43,826)**	**(49,722)**	**(54,806)**	**(50,172)**	**(61,480)**
Other Comprehensive Income	-	86,228	-	-	-	-
(Deficit) / Surplus	**(79,671)**	**42,402**	**(49,722)**	**(54,806)**	**(50,172)**	**(61,480)**

Note: *Included in the 2019/20 audited result is an additional provision of $36.5m for the remediation of the areas of non-compliance in terms of the Holiday's Act that was not included in the budget. The 2021/22 plan includes an additional provision of $20m in terms of the Holiday's Act. The profit and loss for 2020/21 year included in the financial tables is the forecast year end position and is unaudited at the time of this publication.*

Note: *The 2022/23 plan includes a revenue correction assumption of $19.8m for the full correction of the estimated 7,000 uncounted population in the DHBs PBFF Revenue.*

2.2.3 Funder

Revenue	2019/20 Audited Actual	2020/21 Unaudited Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$ 000	$ 000	$ 000	$ 000	$ 000
Ministry of Health	1,660,871	1,803,984	1,875,566	1,988,903	2,087,354	2,190,990
Other Government	133	7,692	8,716	8,888	9,065	9,246
Other	462	37	60	61	62	64
Inter DHB and Internal	96,618	78,944	98,977	103,768	108,957	114,226
Total	**1,758,084**	**1,890,657**	**1,983,319**	**2,101,620**	**2,205,438**	**2,314,526**
Personal Health	1,328,157	1,359,778	1,561,232	1,648,832	1,715,546	1,784,281
Mental Health	167,732	181,797	190,580	198,479	206,632	215,006
Disability Support	184,628	190,896	210,578	221,674	233,761	246,680
Public Health	25,915	54,338	7,578	7,888	8,207	8,535
Maaori	2,826	2,909	2,991	3,114	3,240	3,369
Governance	15,530	15,420	22,683	23,837	25,053	26,333
Total Expenditure	**1,724,788**	**1,805,138**	**1,995,642**	**2,103,824**	**2,192,439**	**2,284,204**
Net Surplus	**33,296**	**85,519**	**(12,323)**	**(2,204)**	**12,999**	**30,322**

2.2.4 Eliminations

Revenue	2019/20 Audited Actual	2020/21 Unaudited Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$ 000	$ 000	$ 000	$ 000	$ 000
Ministry of Health	-	-	-	-	-	-
Other Government	-	-	-	-	-	-
Other	-	-	-	-	-	-
Inter DHB and Internal	920,350	925,795	1,098,923	1,163,744	1,210,278	1,258,098
Total	**920,350**	**925,795**	**1,098,923**	**1,163,744**	**1,210,278**	**1,258,098**
Personal Health	773,930	772,488	934,472	991,950	1,030,782	1,070,589
Mental Health	98,804	105,801	109,683	114,169	118,793	123,533
Disability Support	32,086	32,086	32,085	33,788	35,650	37,643

Public Health	-	-	-	-	-	-
Maaori	-	-	-	-	-	-
Governance	15,530	15,420	22,683	23,837	25,053	26,333
Total Expenditure	**920,350**	**925,795**	**1,098,923**	**1,163,744**	**1,210,278**	**1,258,098**
Net Surplus	**-**	**-**	**0**	**-**	**-**	**-**

2.2.5 Provider

Revenue	**2019/20 Audited Actual**	**2020/21 Unaudited Actual**	**2021/22 Plan**	**2022/23 Plan**	**2023/24 Plan**	**2024/25 Plan**
	$000	**$ 000**	**$ 000**	**$ 000**	**$ 000**	**$ 000**
Ministry of Health	49,877	100,631	40,679	50,440	54,693	58,744
Other Government	38,345	41,646	40,527	41,768	42,744	43,907
Other	41,022	40,921	44,165	45,464	46,514	47,582
Inter DHB and Internal	906,781	913,824	1,078,531	1,142,242	1,187,607	1,234,194
Total	**1,036,025**	**1,097,022**	**1,203,902**	**1,279,914**	**1,331,558**	**1,384,427**
Personnel	754,041	808,566	835,360	891,524	957,057	1,011,538
Outsourced	106,051	119,442	114,524	133,465	110,287	109,031
Clinical Support	131,507	143,921	139,072	148,635	152,971	158,295
Infrastructure	81,543	84,177	82,442	84,241	87,703	89,568
Operating Costs	**1,073,142**	**1,156,106**	**1,171,398**	**1,257,865**	**1,308,018**	**1,368,432**
Operating Surplus / (Deficit)	**(37,117)**	**(59,084)**	**32,504**	**22,049**	**23,540**	**15,995**
Depreciation	40,136	40,872	45,695	49,066	57,545	71,908
Capital Charge	33,625	24,986	23,511	24,975	29,827	37,263
Interest	25	99	242	329	315	300
Net Deficit	**(110,903)**	**(125,041)**	**(36,944)**	**(52,321)**	**(64,147)**	**(93,476)**
Other Comprehensive Income	-	86,228	-	-	-	-
Total Comprehensive Income	**(110,903)**	**(38,813)**	**(36,944)**	**(52,321)**	**(64,147)**	**(93,476)**

2.2.6 Governance

Revenue	2019/20 Audited Actual	2020/21 Unaudited Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$ 000	$ 000	$ 000	$ 000	$ 000
Ministry of Health	15,530	15,420	22,683	23,837	25,053	26,333
Other Government	-	-	-	-	-	-
Other	333	558	170	173	177	180
Inter DHB and Internal	-	-	-	-	-	-
Total	**15,863**	**15,978**	**22,853**	**24,010**	**25,230**	**26,513**
Personnel	11,110	12,565	15,636	16,012	16,408	16,823
Outsourced	1,596	3,714	3,342	3,443	3,546	3,652
Clinical Support	123	50	145	-	-	-
Infrastructure	5,098	3,953	4,186	4,836	4,300	4,364
Total Expenditure	**17,927**	**20,282**	**23,309**	**24,291**	**24,254**	**24,839**
Net Deficit	**(2,064)**	**(4,304)**	**(456)**	**(281)**	**976**	**1,674**

2.2.7 Balance Sheet

	2019/20 Audited Actual	2020/21 Unaudited Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$ 000	$ 000	$ 000	$ 000	$ 000
Current Assets						
Cash and Bank	26,328	18,341	(23,461)	(58,267)	(88,092)	(120,377)
Trust Funds	837	835	835	835	835	835
Debtors	63,991	111,396	111,396	111,396	111,396	111,396
Inventory	11,305	11,586	11,586	11,586	11,586	11,586
Assets Held for Sale	5,320	5,320	5,320	5,320	5,320	5,320
Current Assets Total	**107,781**	**147,478**	**105,676**	**70,870**	**41,045**	**8,760**
Non-Current Assets	**919,622**	**1,022,267**	**1,094,108**	**1,186,068**	**1,335,979**	**1,432,754**
Total Assets	**1,027,403**	**1,169,745**	**1,199,784**	**1,256,938**	**1,377,024**	**1,441,514**
Current Liabilities						
Creditors	139,796	185,730	185,730	185,730	185,730	185,730
Borrowings	-	265	279	293	308	324
Employee Provisions	317,091	351,748	371,748	392,714	414,698	437,753
Total Current Liabilities	**456,887**	**537,743**	**557,757**	**578,737**	**600,736**	**623,807**
Working Capital	**(349,106)**	**(390,265)**	**(452,081)**	**(507,867)**	**(559,691)**	**(615,047)**
Net Funds Employed	**570,516**	**632,002**	**642,027**	**678,201**	**776,288**	**817,707**
Non-Current Liabilities						
Employee Provision	37,267	39,386	39,386	39,386	39,386	39,386
Borrowings	-	1,811	1,532	1,239	931	607
Restricted funds	-	-	-	-	-	-
Other	13,182	15,309	14,965	14,623	14,283	13,945
Total Non-Current Liabilities	**50,449**	**56,506**	**55,883**	**55,248**	**54,600**	**53,938**
Crown Equity	**520,067**	**575,496**	**586,144**	**622,953**	**721,688**	**763,769**
Net Funds Employed	**570,516**	**632,002**	**642,027**	**678,201**	**776,288**	**817,707**

2.2.8 Movement in equity

	2019/20 Audited Actual	2020/21 Unaudited Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$ 000	$ 000	$ 000	$ 000	$ 000
Total Equity at beginning of Period	**565,324**	**520,067**	**575,496**	**586,144**	**622,953**	**721,688**
Deficit for period	(79,671)	(43,826)	(49,722)	(54,806)	(50,172)	(61,480)
Crown Equity injection	33,996	13,446	60,789	92,034	149,329	103,981
Crown Equity withdrawal	(419)	(419)	(419)	(419)	(419)	(419)
Revaluation Reserve	-	86,228	-	-	-	-
Movement in restricted funds	-	-	-	-	-	-
Other movements	837	-	-	-	(3)	(1)
Total Equity at end of Period	**520,067**	**575,496**	**586,144**	**622,953**	**721,688**	**763,769**

2.2.9 Cashflow

	2019/20 Audited Actual	2020/21 Unaudited Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$ 000	$ 000	$ 000	$ 000	$ 000
Operating Activities						
Crown Revenue	1,705,634	1,888,996	1,916,245	2,039,343	2,142,047	2,249,734
Other	174,767	172,627	194,321	201,616	209,063	216,797
Interest receivable	1,007	600	230	500	500	500
Suppliers	(1,106,687)	(1,211,571)	(1,240,886)	(1,315,158)	(1,341,429)	(1,391,477)
Employees	(701,537)	(789,992)	(830,994)	(886,572)	(951,482)	(1,005,305)
Interest paid	-	-	(50)	(150)	(150)	(150)
Capital charge	(33,462)	(25,149)	(23,511)	(24,975)	(29,827)	(37,263)
GST (Net)	230	(546)	-	-	-	-
Net cash from Operations	**39,952**	**34,965**	**15,355**	**14,604**	**28,722**	**32,836**

Investing activities						
Sale of Fixed assets	62	-	9	-	-	-
Total Fixed Assets	(61,118)	(55,252)	(117,536)	(141,025)	(207,457)	(168,683)
Investments and Restricted Trust Funds	(588)	(729)	-	-	-	-
Net cash from Investing	**(61,644)**	**(55,981)**	**(117,527)**	**(141,025)**	**(207,457)**	**(168,683)**
Financing						
Crown Debt	-	-	-	-	-	-
Equity – Capital	33,577	13,027	60,370	91,615	148,910	103,562
Net appropriation to/from Trust funds	-	-	-	-	-	-
Net cash from Financing	**33,577**	**13,027**	**60,370**	**91,615**	**148,910**	**103,562**
Net increase / (decrease)	11,885	(7,989)	(41,802)	(34,806)	(29,825)	(32,285)
Opening cash	15,280	**27,165**	**19,176**	**(22,626)**	**(57,432)**	**(87,257)**
Closing cash	**27,165**	**19,176**	**(22,626)**	**(57,432)**	**(87,257)**	**(119,542)**

2.2.10 Capital expenditure

	2019/20 Audited Actual	2020/21 Unaudited Actual	2021/22 Plan	2022/23 Plan	2023/24 Plan	2024/25 Plan
	$000	$ 000	$ 000	$ 000	$ 000	$ 000
Baseline Capital	25,646	22,406	36,430	49,066	50,935	71,908
Strategic Capital	35,472	32,846	81,106	91,959	156,522	96,775
Total	**61,118**	**55,252**	**117,536**	**141,025**	**207,457**	**168,683**

2.3 Accounting policies

The forecast financial statements have been prepared on the basis of the significant accounting policies, which are expected to be used in the future for reporting historical financial statements. The significant accounting policies used in the preparation of these forecast financial statements included in this Annual Plan are summarised below. A full description of accounting policies used by CM Health for financial reporting is provided in the Annual Reports that are published on the CM Health website: https://countiesmanukau.health.nz

2.3.1 Reporting entity

CM Health is a Crown entity as defined by the Crown Entities Act (2004) and is domiciled in New Zealand. The DHB's ultimate parent is the New Zealand Crown. CM Health has designated itself and the group as a public benefit entity

(PBE) for financial reporting purposes. CM Health's activities range from delivering health and disability services through its public provider arm to shared services for both clinical and non-clinical functions e.g. laboratories and facilities management, as well as planning health service development, funding and purchasing both public and non-government health services for the district.

The forecast consolidated financial statements of CM Health comprise our interest in associates and jointly controlled entities. The CM Health group consists of the parent, CM Health and its Joint ventures healthAlliance N.Z. Limited (25 percent); HealthSource New Zealand Limited (25 percent) and NZ Health Partnerships Limited (5 percent). It has an Associate investment in Northern Regional Alliance Limited (33.3 percent). The DHB's associates and joint venture are incorporated and domiciled in New Zealand.

2.3.2 Basis of preparation

Health Sector Reforms

On 21 April 2021, the Minister of Health announced the health sector reforms in response to the Health and Disability System Review.

The reforms will replace all 20 DHBs with a new Crown entity, Health New Zealand, which will be responsible for running hospitals and commissioning primary and community health services. It will have four regional divisions.

As a result of the reforms, responsibility for public health issues will rest with a new Public Health Authority. A new Māori Health Authority will monitor the state of Māori health and commission services directly.

Legislation to establish the new entities and disestablish DHBs is scheduled to come into effect on 1 July 2022.

Because of the expected date of these reforms the forecast financial statements of the DHB have been prepared on a disestablishment basis. No changes have been made to the recognition and measurement, or presentation in these forecast financial statements, because all assets, liabilities, functions and staff of the DHBs and shared services agencies will transfer to Health New Zealand.

The accounting policies have been applied consistently throughout the period.

2.3.3 Statement of compliance

The forecast financial statements of the DHB have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act (2000) and the Crown Entities Act (2004), which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). These forecast financial statements have been prepared in accordance with *PBE-FRS 42: Prospective Financial Statements*. These forecast financial statements comply with Public Sector PBE accounting standards. The forecast financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

2.3.4 Presentation currency and rounding

The consolidated forecast financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

2.3.5 Forecast information

In preparation of the forecast financial statements, the DHB has made estimates and assumptions concerning future events. The assumptions and estimates are based on historical factors and other factors including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions may differ from subsequent actual results.

The profit and loss for 2020/21 year included in the financial tables is the actual year end position and is unaudited at the time of this publication.

The accounting policies applied in the projected financial statements are set out in section 2.6

2.4 Significant assumptions

2.4.1 General

Overall, we remain confident of meeting all reasonably anticipated cash outflows for 2021/22 through both the achievement of a positive operating cash position and utilisation for capital purposes, of the existing un-utilised/approved debt facilities. Continued cash flow support from the MoH will be required to manage any Holiday's Act and COVID19 related cash flow impacts.

Where previously there appeared to be significant opportunity to continue to improve efficiencies and limit the cost impact of growth, the current outlook provides much more limited opportunities in these historical areas.

In response, CM Health has taken a whole of system approach to value creation, quality and safety, productivity enhancement and efficiency. This approach includes consistent focus on clinical leadership, process realignment, integration and new models of care.

2.4.2 Personnel costs

Despite the international economic position, the anticipated level of clinical wage settlements will continue to be an on-going challenge in relation to the mismatch of health worker wage/salary expectations and affordability. The annualised on-going cost of settlement is 1.9 percent – 5 percent due to automatic on-going step functions, on-cost implications and increasing entitlements. Combined, these costs are greater than the Crown Funding growth and need to be absorbed by internal efficiencies and other initiative savings. Acknowledging the State Service Commission advice following COVID, assumptions for 2021/22 have been applied at 1.5% for staff < $100k and 0% for all others.

We continue to manage management and administration FTEs. Despite this, we have prioritised personnel costs to support acceleration of essential health system integration, whole of system programmes and related activities. This requires commitment to project, programme, analytical and change management resource to be successful.

2.4.3 Third party and shared services provision

Focus for 2021/22 continues to be alignment of localities development and related primary care/community services. The form that investment will take is still evolving and there is an expectation of increased third party participation and provision of public services integrated with core/essential CM Health services. Regional service planning and the Northern Region Long Term Investment Plan priorities will inform this.

Capital investment constraints and increasing health target expectations are likely to require a closer look at third party and shared regional capacity expansion. This will include a strong direction regarding increased provision of shared services, through HealthSource New Zealand Limited (HealthSource) with heightened reliance around realisation of tangible savings.

2.4.4 Supplies

CM Health is working very closely with and contributing to, the national procurement and supply chain efficiency objectives. Regional efficiencies through shared services provided by HealthSource will be included in the living within our means projects.

2.4.5 Services by other DHBs and regional providers

There is a significant commitment to regional cooperation and alignment of service provision to reduce wastage from unnecessary variation and better leverage of the region's collective expertise. CM Health contributes to the regional Service Review Group, Clinical Networks and range of other forums to support effective service delivery across the metropolitan Auckland region.

The continuing commitment (albeit constrained) to investment in priority initiatives aligned with the Northern Region Health Plan and Long Term Investment Plan; including those focused on slowing the growth of hospital services and the improving quality and consistency of care.

2.4.6 Other primary and community care contracts

Historically there has been Mental Health under-spends which are essentially timing issues rather than permanent under-spends. These benefits have been approved to fund urgently needed mental health facilities planned for 2018/19 to 2020/21.

Publicly ACC has indicated a tighter fiscal affordability envelope and as well, a tightening of their payment parameters. While this is difficult to quantify currently, CM Health expects to offset any downside by further opportunities or enhancement of existing contracts.

2.4.7 Enabling technology infrastructure

Prioritised Information System (IS) infrastructure (technology) investment has been agreed regionally and funded by healthAlliance and is essential for health system business continuity and effective implementation of integration models of care between secondary and primary/community care settings. The capital commitment for the regional DHBs collectively is significant. This investment will target IS infrastructure resilience that will provide a sound foundation for shared clinical and business information systems. Refer to the Data and Digital Priority in Section 2.7.6 and Section 4.5.2 of the Annual Plan for an outline of regional IS investments and local innovations. The net financial impacts will include both capital and operational costs.

2.4.8 Capital investment

CM Health's Long Term Investment Plan supports the strategic priority to move away from reliance on physical brick and mortar solutions to manage capacity growth and adopt whole of system solutions with a focus on community based service expansion. The realities of high hospital service demand now mean we need to augment this strategic priority with a regional approach to investments to address urgent inpatient bed capacity and related hospital services and site investments. Development of the Northern Regional Long Term Investment Plan (NRLTIP) is evaluating where and when potential new hospital sites will be required to manage the region's significant future growth. Regional service planning continues to seek opportunities to leverage regional capacity as a means of meeting short to medium term demand for health services.

CM Health's changing financial position has required a reassessment of local capital investment prioritisation. Figure 1 below illustrates the likely cash-flow profile for major capital projects approved or currently within the pathway for approval. This includes:

- a second Cardiac Cath lab
- an additional Gastro procedure room
- a Renal dialysis unit expansion
- additional cots in Neonates
- increased capacity at Manukau Health Park incorporating additional Theatres, Outpatients, Radiology and the enabling infrastructure costs.

Figure 2 below outlines likely major capital (projects greater than $5m) investment projects, which are dependent on confirmation of Northern Region Long Term Investment Plan priorities, related service change reviews in progress and

confirmation of affordability. These investments reflect a mix of repair for existing facilities, expansion to meet service capacity demands and model of care changes for future sustainability.

Once the abovementioned evaluation is complete Counties Manukau District Health Board will submit the detailed business cases to the Northern Region governance groups, then onto the MOH and Treasury. Many capital investments require regional service review processes to ensure the most effective allocation of resources and quality of service. Local and regional Information and Communication Technology investments are planned regionally through the Regional Information Services Strategic Plan.

Figure 1: Approved Major Facilities Capital Projects >$5m as presented in the 2021/22 – 2024/25 Annual Plan

Major Facilities Project	Planned Funding Source	Forecast 2020/21 $000	2021/22 $000	Year 2-5 $000	Year 6-10 $000	Outer years > 10 years $000	Total $000
Acute Mental Health Unit	Crown	25,600	-	-	-	-	25,600
Scott Building Recladding	Crown + CM Health	26,500	1,000	-	-	-	27,500
Scott Dialysis & Cath Lab	CM Health	4,371	11,736	-	-	-	16,107
Gastroenterology Expansion	CM Health	3,839	3,035	-	-	-	6,873
Harley Gray Radiology Relocation	Crown	486	1,835	19,679	-	-	22,000
Manukau Health Park - Phase 1 (note 1)	Crown + CM Health	8,762	47,623	172,975	6,540	-	235,900
Building recladding - Kidz First, McIndoe and Manukau Elective Surgical Hospital	Crown	630	11,570	42,800	-	-	55,000
Neonates (additional cots)	Crown	1,528	3,472	-	-	-	5,000
Sub Total		**71,715**	**80,271**	**235,455**	**6,540**	**-**	**393,980**

Figure 2: Unapproved Major Facilities Capital Projects >$5m

Major Facilities Project	Planned Funding Source	Forecast 2020/21 $000	2021/22 $000	Year 2-5 $000	Year 6-10 $000	Outer years > 10 years $000	Total $000
Grow Manukau							
Cancer Centre (incl Linac)	Crown	-	-	100,000	-	-	100,000
Manukau Carparking	Crown	-	-	20,000	-	-	20,000
Manukau Infrastructure - Phase 2	Crown	-	-	-	60,000	60,000	120,000
Manukau Support Services - Phase 2	Crown	-	-	-	31,500	31,500	63,000
Manukau Outpatients - Phase 2	Crown	-	-	-	80,000	80,000	160,000
Manukau Radiology Hub - Phase 2	Crown	-	-	-	12,000	12,000	24,000
Elective Surgery Centre - Phase 2	Crown	-	-	-	145,000	145,000	290,000
Immediate Remediation							
Otara Spinal Unit and Adult Rehabilitation Replacement	Crown + CM Health + Donations	-	836	144,159	-	-	144,995
Grow Middlemore							
Replace Galbraith & growth							
Core Infrastructure (Galbraith - phase 1)	Crown	2,000	4,000	14,000	-	-	20,000
Maternity & Gynaecology (100 beds)	Crown	-	-	37,500	112,500	-	150,000
Inpatient Ward block (6 wards)	Crown	-	-	75,000	225,000	-	300,000
Critical Infrastructure (MMH - phase 2)	Crown	-	-	20,000	20,000	-	40,000
Colvin Replacement	Crown	-	-	-	55,000	55,000	110,000
Theatres & radiology expansion (Harley Gray - Stage 2)	Crown	-	-	-	96,000	-	96,000
ED and Critical Care refurbishment and expansion	Crown	-	-	-	144,000	-	144,000
Helipad	Crown	-	-	-	10,000	-	10,000
Cath lab (additional capacity)	Crown	-	-	-	20,000	20,000	40,000
Gastro procedure theatres (additional capacity)	Crown	-	-	-	-	10,000	10,000
Middlemore Carparking	Crown	-	-	-	24,600	-	24,600
Critical Infrastructure (MMH - phase 3)	Crown	-	-	-	20,000	20,000	40,000
Whanau support / accommodation (10 suites)	Donations	-	-	-	5,000	-	5,000
Grow community hubs							
Botany Hub and replace Primary Maternity unit	Crown	-	-	-	40,000	-	40,000

Otara Hub and replace Tamaki Oranga (Adult Mental Health)	Crown	-	-	-	-	49,600	49,600
Manukau Station Rd - arrangement with a developer (Clin Equip, FF&E)	Crown	-	-	15,000	-	-	15,000
Community Hubs	Crown	-	-	47,000	53,000	-	100,000
New Acute Hospital							
Southern site land acquisition	Crown	-	-	50,000	-	-	50,000
New Southern Hospital Stage 1	Crown	-	-	-	-	960,000	960,000
Sub Total		**2,000**	**4,836**	**522,659**	**1,153,600**	**1,443,100**	**3,126,195**
Totals		**73,715**	**85,106**	**758,114**	**1,160,140**	**1,443,100**	**3,520,175**

2.4.9 Capital investment funding

Capital investment will be funded from a number of sources including working capital, crown funding, leases and operating surpluses.

2.4.10 Banking

CM Health operates under no banking covenant; all previous crown debt has now been converted to Equity. The Counties Manukau District Health Board maintains a working capital facility with New Zealand Health Partnerships via the Bank of New Zealand, together with lease/finance facilities with both Commonwealth Bank and Westpac.

Figure 1: Banking facilities

Facilities	Available Facility at 1 July 2021 $000,000
NZ Health Partnerships (working capital)	$75.5
Lease facilities	$15.0

2.4.11 Property, plant and equipment

CM Health revalue property, plant and equipment in accordance with the Public Benefit Entity International Public Sector Accounting Standard 17: Property, Plant and Equipment. CM Health land and buildings are revalued every five years or where there is a material change. The last building revaluation occurred in 30 June 2019 on an 'Optimised Depreciated Replacement Costs' basis. The forecast 2020/21 balance sheet includes an unaudited adjustment for the revaluation of land as at 30 June 2021.

There is recognition of the rising burden of clinical equipment replacement and this has accelerated CM Health's commitment to an Enterprise Asset Management System, with continued roll out in 2021/22.

2.5 Additional Information and Explanations

2.5.1 Disposal of land

In compliance with clause 43 of schedule 3 of the New Zealand Public Health and Disability Act 2000, CM Health will not sell, exchange, mortgage or charge land without the prior written approval of the Minister of Health. CM Health will comply with the relevant protection mechanism that addresses the Crown's obligations under the Treaty of

Waitangi and any processes related to the Crown's good governance obligations in relation to Maaori sites of significance.

2.6 Significant Accounting Policies

Subsidiaries

Subsidiaries are entities controlled by Counties Manukau DHB. Counties Manukau DHB does not have any subsidiaries to consolidate.

Investments in Associates and Jointly Ventures

Associates are those entities in which Counties Manukau DHB has significant influence, but not control, over the financial and operating policies. Significant influence is presumed to exist when Counties Manukau DHB holds between 5-33 percent of the voting power of another entity. Joint ventures are those entities over whose activities Counties Manukau DHB has joint control, established by contractual agreement and requiring unanimous consent for strategic financial and operating decisions. Associates and Joint Ventures are not accounted for using the equity method or proportionate method, as they are not material.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

MOH Revenue

Funding is provided by the MOH through a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the Appropriation equally throughout the year.

The revenue recognition approach for MOH contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantially linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as Counties Manukau DHB provides the service.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. Judgement is required in determining the timing of revenue recognition for contracts that span balance date and multi-year funding agreements

ACC Contract Revenues

ACC contract revenue is recognised as revenue when eligible services are provided and contract conditions have been fulfilled.

Rental Income

Rental income is recognised as revenue on a straight-line basis over the term of the lease.

Revenue relating to service contracts

Revenue from services rendered is recognised in profit or loss in proportion to the stage of completion of the transaction at the reporting date. The stage of completion is assessed by reference to surveys of work performed.

Revenue from other DHBs

Inter-district patient inflow revenue occurs when a patient treated within the Counties Manukau DHB region is domiciled outside of Counties Manukau. The MOH credits Counties Manukau DHB with a monthly amount based on estimated patient treatment for non-Counties Manukau residents within Counties Manukau. An annual wash-up occurs at year end to reflect the actual number of non-Counties Manukau patients treated at Counties Manukau DHB.

Interest income

Interest income is recognised using the effective interest method.

Donations and bequests

Donations and bequests to the DHB are recognised as revenue when control over the asset is obtained. Those donations and bequests for specific purposes are transferred from accumulated surpluses/(deficits) to the trust funds component of equity. When expenditure is subsequently incurred in respect of these funds, it is recognised in the surplus or deficit prior to other comprehensive income and an equivalent amount is transferred from the trust component of equity to accumulated surpluses/(deficits).

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Interest expense

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

Leases

Finance leases

A finance lease is a lease that transfers to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred.

At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased item or the present value of the minimum lease payments. The finance charge is charged to the surplus or deficit prior to other comprehensive income over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over its useful life. If there is no certainty that the DHB will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the lease term and its useful life.

Operating leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

Lease incentives received are recognised in the surplus or deficit prior to other comprehensive income over the lease term as an integral part of the total lease expense.

Cash and cash equivalents

Cash and cash equivalents includes cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts.

Bank overdrafts are shown as borrowings in current liabilities in the statement of financial position.

Debtors and other receivables

Debtors and other receivables are recorded at their face value, less provision for impairment.

A receivable is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership, or liquidation, and default in payments are considered indicators that the debtor is impaired. The DHB uses a provision

matrix to calculate the expected credit loss (ECL) for non-resident debtors. The provision rates are based on days past due. The ECL calculation is initially based on the historical observed default rates. The DHB will adjust historical credit loss experience with forecast economic conditions if they are expected to change over the next year.

The amount of the impairment is the difference between the asset's carrying amount and the present value of estimated future cash flows. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectible, it is written off against the allowance account for receivables. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

Investments

Bank deposits

Investments in bank deposits are initially measured at fair value.

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

A bank deposit is impaired when there is objective evidence that the DHB will not be able to collect amounts due. Significant financial difficulties of the bank, probability that the bank will enter into receivership or liquidation, and default in payments are considered indicators that the deposit is impaired.

Inventories

Inventories held for distribution or consumption in the provision of services that are not supplied on a commercial basis are measured at cost (using the FIFO method), adjusted, when applicable, for any loss of service potential. The loss of service potential of inventories held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the lower of cost or replacement cost at the date of acquisition.

The amount of any write-down for the loss of service potential is recognised in surplus or deficit prior to other comprehensive income in the period of the write-down.

Non-Current assets held for sale

Non-Current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-Current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of Non-Current assets held for sale are recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-Current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

Property, plant, and equipment

Property, plant, and equipment consist of the following asset classes:

- land;
- buildings, plant and infrastructure;
- clinical equipment, IT and motor vehicles;
- other equipment; and

- work in progress.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation and impairment losses. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years.

The carrying values of land and buildings are assessed annually by independent valuers to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

Revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive income and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit prior to other comprehensive income will be recognised first in the surplus or deficit prior to other comprehensive income up to the amount previously expensed, and then recognised in other comprehensive income.

Additions

The cost of an item of property, plant, and equipment is recognised as an asset only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. The cost of self-constructed assets includes the cost of materials, direct labour, the costs of dismantling and removing the items and restoring the site on which they are located if relevant, an appropriate proportion of direct overheads and capitalised borrowing costs.

Work in progress is recognised at cost, less impairment, and is not depreciated.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to accumulated surpluses.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant, and equipment are recognised in the surplus or deficit prior to other comprehensive income as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant, and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Figure 2: Depreciation rates of assets

Class of Asset	Estimated Life	Depreciation Rate
Buildings		
Structure/Envelope	5 - 100 years	1% - 20%
Electrical Services	5 - 15 years	6% - 20%
Other Services	5 - 25 years	4% - 20%
Fit out	5 - 10 years	10% - 20%
Infrastructure	2 - 100 years	1% - 50%
Plant and equipment	5 - 10 years	10% - 20%
Clinical Equipment	1 - 15 years	6% - 100%
Information Technology	1 - 8 years	12.5% - 100%
Vehicles	1 – 12.5 years	8% -100%
Other Equipment	1 - 14 years	7% - 100%

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year end.

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include the software development employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Finance Procurement and Information Management System (FPIM)

The Finance Procurement and Information Management System (FPIM) is a national initiative funded by DHBs and facilitated by NZ Health Partnerships Limited (NZHPL) to deliver sector wide benefits. NZHPL holds an intangible asset recognised at the capital cost of development relating to this programme. CMDHB holds an asset at cost of capital invested by CMDHB in the FPIM Programme. This investment represents the right to access the FPIM assets and are considered to have an indefinite life. DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by NZHPL through the on-charging of depreciation and amortisation on the assets to the DHBs will be used to, and is sufficient to, maintain the assets standard of performance or service potential indefinitely. As the rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

CMDHB holds:

- an intangible asset for the cost of capital invested by CMDHB in the FPIM application. This is amortised over 14 years and amortisation commenced in the 2019/20 year;
- an intangible asset for the cost of capital invested by CMDHB in the FPIM central implementation costs. This will be amortised over 15 years when the asset is brought into use in October 2020 (as at 30 June 2020 these costs paid to date are recognised as a prepayment); and

- a prepayment for the costs paid in relation to the core build of the FPIM Hardware. This will be recognised as an expense over five-year period from October 2020.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows: Acquired computer software 2-5 years (20 percent – 50 percent)

Impairment of Property, Plant & Equipment and Intangible Assets

Counties Manukau DHB does not hold any cash generating assets. Assets are considered cash generating where their primary objective is to generate a commercial return.

Property, Plant & Equipment and Intangible Assets are reviewed for indicators of impairment as at each balance date. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount.

The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is depreciated replacement cost for an asset where the service potential of the asset is not primarily dependent on the asset's ability to generate net cash inflows and where the DHB would, if deprived of the asset, replace its remaining service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written-down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

For assets not carried at re valued amount, the reversal of an impairment loss is recognised in the surplus or deficit.

Creditors and other payables

Creditors and other payables are generally settled within 30 days so are recorded at their face value.

Borrowings

Borrowings are initially recognised at their fair value. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless the DHB has an unconditional right to defer settlement of the liability for at least 12 months after the balance date.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned to but not yet taken at balance date, continuing medical education leave, and sick leave.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past, practice that has created a constructive "obligation".

Long-term entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as sick leave, long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- Likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information; and
- The present value of the estimated future cash flows.

Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash outflows for entitlements. The inflation factor is based on the expected long-term increase in remuneration for employees.

Presentation of employee entitlements

Continuing medical education leave, annual leave, and vested long service leave and sabbatical leave are classified as a current liability. Non-vested long service leave, retirement gratuities and sick leave expected to be settled within 12 months of balance date are classified as a current liability. All other employee entitlements are classified as a non-current liability.

Superannuation schemes

Defined contribution schemes

Employer contributions to Kiwi Saver, the Government Superannuation Fund, and the State Sector Retirement Savings Scheme are accounted for as defined contribution schemes and are recognised as an expense in the surplus or deficit prior to other comprehensive income as incurred.

Defined benefit scheme

Counties Manukau DHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme the extent to which the surplus/deficit in the plan will affect future contributions by individual employers, because there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditure will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are not recognised for future operating losses.

Restructuring

A provision for restructuring is recognised when the DHB has approved a detailed formal plan for the restructuring which has either been announced publicly to those affected, or for which implementation has already commenced.

ACC Partnership Programme

The DHB belongs to the ACC Partnership Programme whereby it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the program, it is liable for all its claims costs for a period of four years up to a specified maximum amount. At the end of the four-year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of employee injuries and claims up to balance date.

Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Revaluation reserves

These reserves are related to the revaluation of land and buildings to fair value.

Trust funds

This reserve records the unspent amount of donations and bequests provided to the DHB.

Goods and services tax

All items in the forecast financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense. The GST (net) component of cash flows from operating activities reflects the net GST paid to and received from the IRD. The GST (net) component has been presented on a net basis, as the gross amounts do not provide meaningful information for the forecast financial statement purposes and to be consistent with the presentation basis of the other primary forecast financial statements.

The net amount of GST recoverable from, or payable to, the IRD is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

The DHB is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

Cost Allocation

Counties Manukau DHB has arrived at the net cost of service for each significant activity using the cost allocation system outlined below.

- Direct costs are those costs directly attributable to an output class.
- Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.
- Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity and usage information.
- The cost of internal services not directly charged to outputs is allocated as overheads using appropriate cost drivers such as actual usage, staff numbers and floor area.

There have been no changes to the cost allocation methodology since the date of the last audited financial statements.

Critical accounting estimates and assumptions

In preparing these forecast financial statements, the Board has made estimates and assumptions concerning the future.

These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Land and buildings revaluations

The significant assumptions applied in determining the fair value of land and buildings.

Estimating useful lives and residual values of property, plant, and equipment

At each balance date, the useful lives and residual values of property, plant, and equipment are reviewed.

Assessing the appropriateness of useful life and residual value estimates requires the DHB to consider a number of factors such as the physical condition of the asset, advances in medical technology, expected period of use of the asset by the DHB, and expected disposal proceeds (if any) from the future sale of the asset.

An incorrect estimate of the useful life or residual value will affect the depreciation expense recognised in the surplus or deficit prior to other comprehensive income and the asset's carrying amount. The DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets
- Asset replacement programs
- Review of second-hand market prices for similar assets; and
- Analysis of prior asset sales

The DHB has not made significant changes to past assumptions concerning useful lives and residual values.

Retirement and long service leave

Retirement and long service leave provisions are subject to a number of estimates and uncertainties surrounding the timing of retirement and the uptake.

Critical judgements in applying accounting policies

Management has exercised the following critical judgements in applying accounting policies:

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments.

Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised.

The DHB has exercised its judgement on the appropriate classification of leases, and has recognised no leases as finance leases.

Agency relationship

Determining whether an agency relationship exists requires judgement as to which party bears the significant risks and rewards associated with the sale of goods or the rendering of services. This judgement is based on the facts and circumstances that are evident for each contract and considering the substance of the relationship.

For a number of contracts Counties Manukau DHB makes payments to the service providers on behalf of the DHBs receiving services. These DHBs will then reimburse Counties Manukau DHB for the costs of the services provided in their districts. Where Counties Manukau DHB has assessed that it has acted as an agent for the other DHBs, payments and receipts in relation to the other DHBs are not recognised in the Counties Manukau DHB forecast financial statements.

Appendix 2: System Level Measures Improvement Plan

System Level Measures Improvement Plan

Auckland, Waitemata &
Counties Manukau Health Alliances

2021
2022

FINANCIAL YEAR

***Tawhiti rawa tō tātou haerenga te kore haere tonu, maha rawa wā tātou mahi te kore mahi tonu*.**

We have come too far to not go further and we have done too much to not do more.

– Sir James Henare

Photo Credit (cover): John Hettig Westone Productions

CONTENTS

1. EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitemata Alliance Leadership Teams (the Alliances) have jointly developed a 2021/22 System Level Measures Improvement Plan.

Continuing with the *one team* theme in the New Zealand Health Strategy, the joint approach to development of the single improvement plan will ensure streamlined activity and reporting, and best use of resources within the health system.

Extensive consultation was carried out across the sector in the development of the 2018/19 System Level Measures Improvement Plan. This year's plan is a further consolidation of the 2018/19 plan. The Covid-19 pandemic has had a significant impact on the delivery of the SLM programme. Primary care capacity to engage with a broad plan has been reduced. The 2021/22 plan has been through a prioritisation process to focus on post-pandemic priorities.

Some activities from previous plans have been removed as they have been successfully achieved. Some have been found to be impractical or not easily measurable. These too have been removed. Activities have been included where they can be expected to have an impact on health outcomes, system efficiency, or a more integrated approach to care. The focus is on areas where there is the greatest need and, where possible, robust data can be used for quality improvement.

Following guidance from the Ministry of Health, much of the plan and contributory measures included in the 2020/21 plan are continuing in the current plan, with refinements where data is not currently available. In some cases, data collection and quality improvement are included in the plan as activities to support contributory measures.

The Alliances are firmly committed to including additional well-aligned contributory measures over a three year timeframe, as the structures, systems and relationships to support improvement activities are further embedded. This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples.

The district health boards (DHBs) included in this improvement plan are:

- Auckland DHB;
- Waitemata DHB, and
- Counties Manukau DHB.

The primary health organisations (PHOs) included in this improvement plan are:

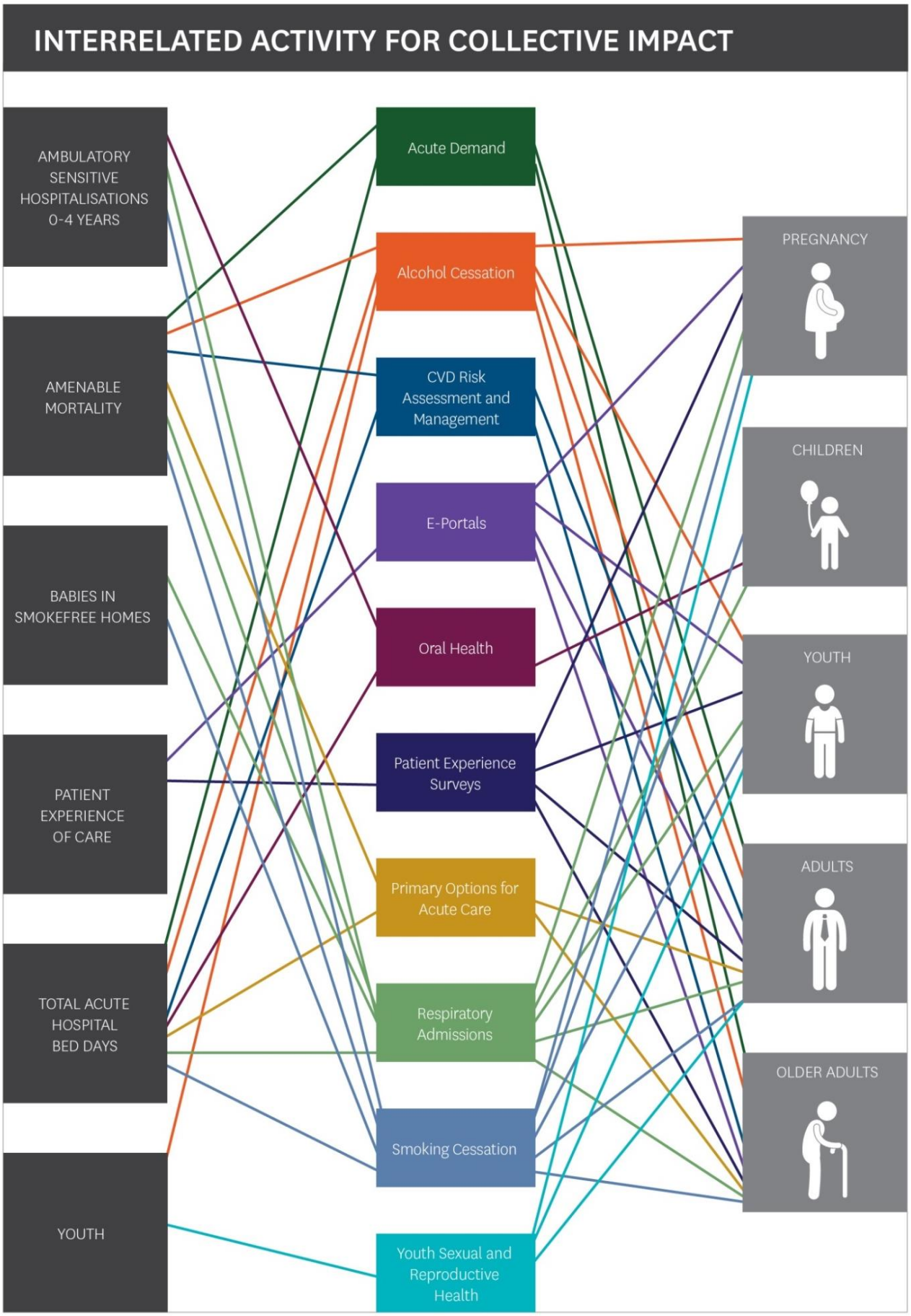
- Alliance Health Plus Trust;
- Auckland PHO;
- East Health Trust;
- National Hauora Coalition;
- ProCare Health;

- Total Healthcare PHO, and
- Comprehensive Care.

The diagram below shows an overview of the relationship between milestones and key activities chosen for the Metro Auckland System Level Measures, and the stage of life they represent. The current plan will maintain this approach of supporting activities and contributory measures that will have impact on multiple milestones.

The plan continues to promote a prevention approach and a strong focus on improving equity of outcome for Māori and other populations with high health need across the greater Auckland region.

2. *INTERRELATED ACTIVITY FOR COLLECTIVE IMPACT*



3. *PURPOSE*

This document outlines how the 2021/22 SLM Improvement Plan will be applied across the Metro Auckland region. It summarises how improvement will be measured for each SLM and the activities that will be fundamental to this improvement. Please note that, as further discussed in section 4, implementation planning is developed and carried out annually.

4. BACKGROUND

The New Zealand Health Strategy outlines a high-level direction for New Zealand's health system over 10 years to 2026, to ensure that all New Zealanders live well, stay well and get well. One of the five themes in the strategy is 'value and high performance' 'te whāinga hua me te tika o ngā mahi'. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health has worked with the sector to develop a suite of SLMs to encourage quality improvement and integration within the health system. The Alliances are required to develop an improvement plan for each financial year in accordance with Ministry of Health expectations. The improvement plan must include the following:

a) Six SLMs:
   - ambulatory sensitive hospitalisation rates per 100,000 for 0 – 4 year olds
   - total acute hospital bed days per capita
   - patient experience of care
   - amenable mortality rates
   - youth access to and utilisation of youth-appropriate health services, and
   - babies living in smokefree homes.

b) Each SLM, has an improvement milestone to be achieved in 2021/22. The milestone must be a number that shows improvement (either for Māori, total population, or a specifically identified population to address equity gaps) for each of the six SLMs.

c) A brief description of activities to be undertaken by all alliancing partners (primary, secondary and community) to achieve the SLM milestones.

d) Contributory measures for each of the six SLMs that is chosen by the district alliance based on local needs, demographics and service configurations that enable the alliance to measure local progress against the SLM activities.

e) Signatures of all district alliance partners to demonstrate an integrated and partnership approach to the development and implementation of the improvement plan.

In 2016, the Counties Manukau Health and Auckland Waitemata Alliances agreed to a joint approach to the development of the SLM Improvement Plan. This included the establishment of a Metro Auckland Steering Group and working groups for each SLM. Steering Group membership includes senior clinicians and leaders from the seven PHOs and three DHBs. The Steering Group is accountable to the Alliances and provides oversight of the overall process.

In 2021/22, SLMs continue to be business-as-usual. The plan follows on from the previous plan, recognising the sector-wide focus on pandemic response to COVID, and the requirements to roll out COVID vaccines and participation in the Measles Catch Up Campaign. The plan prioritises health promotion and disease prevention and management activities such as referring current smokers to smoking cessation support services, improvement in prescribing medication to support smoking cessation, and improvements in management for those with high cardiovascular disease risk, especially Māori and Pacific people. The aim of these activities is to keep people well and out of hospital, which will demonstrate good stewardship and commitment to high quality care. The governance structure of Alliance Leadership and Steering Group continue to guide improvement processes. The responsibility for implementation sits primarily

with the Implementation Groups. These groups have primary care representation and flexible subject matter expertise dependant on topic and requirements, which supports the goal of a more integrated health system. The Implementation Groups have been meeting fortnightly during 2020/21 to further develop key actions (particularly at a local level) and inform implementation planning, monitor data, facilitate systems partnerships, and collaboratively guide the ongoing development of the SLMs with the Steering Group and Alliance Leadership Teams.

We continue to benefit from PHO leadership. The role of PHO lead has been retained from the original working group structure, and leads now have responsibility for diffused matrix management of SLM planning and implementation in their key activity areas. They continue to engage with other system partners.

Data sharing between primary, secondary, and community care providers is progressing under the Metro Auckland Data Sharing Framework. This allows data matching with primary care and non-primary care data sources, more consistent reporting, establishment of baseline performance across DHBs and PHOs and drives quality improvement facilitated by the Implementation Groups.

Reporting processes, both at a local and regional level have been embedded and DHBs and PHOs have access to both static and dynamic reporting in order to monitor progress and identify opportunities for improvement and individual performance is routinely discussed supportively in the Implementation Groups.

4.1 Equity Approach, Consultation and Partnership

This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples. In planning, each contributor has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those with the poorest health outcomes.

Consultation prior to and during planning for 2018/19 was more extensive than previous years. This process was extended to better address the expectations of mana whenua, and to discuss decision-making proactively. In addition, the Māori health gain teams across the region were invited to workshop the concepts and various drafts of the plan and provided valuable input. Feedback received from the engagement sessions with stakeholders was incorporated into development of the improvement plan. This included a sector-wide pre-planning workshop, cultural consultation workshops, consumer meetings, and a presentation of draft measures, milestones and interventions to stakeholders, the Steering Group and Alliances. Feedback received from the engagement sessions was incorporated into development of the improvement plan.

The 2018/19 Improvement Plan was shared with the DHB Māori, Pacific and Asian health gain teams and their feedback was incorporated. Consultation with other relevant cultural groups and equity partners has been an essential part of this process. The 2018/19 SLM Improvement Plan was designed to align with DHB Māori Health Plans.

The 2021/22 plan follows on from the previous year, which was a consolidation of the above referenced 2018/19 plan and therefore continues with a strong focus on equity. Each year builds on the strengths of the previous year to ensure continuous quality improvement.

4.2 Regional Working

As in previous years, a single improvement plan has been developed in 2021/22 for the Alliances and three Metro Auckland DHBs. As a number of PHOs cross the Metro Auckland DHB boundaries and are members of both Alliances this is considered the most practical and achievable approach given limited resources. Improvement milestones and contributory measures have been carefully selected to take into account the context, population and current performance of each DHB in the wider Auckland region. One regional plan also promotes closer regional collaboration between stakeholders, and ensures that patient outcomes are promoted in a consistent way.

4.3 2021/22 Priorities for System Level Measures

The 2021/22 plan continues to focus on cross–system activities which have application to multiple milestones as demonstrated in the 'interrelated activity for collective impact' diagram in Section 2. An extensive stocktake was conducted with both primary and secondary care stakeholders to establish the uptake of the SLM activities, identify barriers and focus on the areas for prioritisation was completed to support the development of the 2019/20 plan, and continues to inform the current work. The results of the stocktake were discussed with the Implementation Group and clinical leaders before being considered by the Steering Group. The aim was to consolidate the plan and think of implementation over a longer timeframe, with achievement of one activity supporting the logical next step in improvement. This plan reflects this longer term approach.

The Covid-19 pandemic has placed significant demands on the health sector, and continues to do so as the vaccine is rolled out in Auckland. This year's plan has been influenced by this event and has a focus on reducing health risks by supporting smoking cessation and preventing hospitalisation by improving the quality and integration of care in the community. Other priorities include greater use of patient portals to improve efficient delivery of care and better management of cardiovascular risk factors for both primary and secondary prevention. The 2021/22 plan aligns with the current priorities within the sector on improving management of long term conditions, prioritising youth health, and promoting a healthy start in the first 4000 days of life.

The plan has been developed using a medium term approach. It includes immediate activity that will contribute to goals to be achieved within three years and taking into consideration the ongoing demands on the health sector. This year we continue to support the essential work that is the foundation for quality improvement activities, including enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

Overarching priorities for 2021/22 continue to adopt a prevention and health promotion approach, and focus on improvements in equity of outcome or access. These activities support intervention in high risk populations, and collective impact. They were developed and planned with a population focus that included specific consultation with patients, family and whānau, and community. Some contributory measures aim for improvement in specific populations such as Māori and Pacific, particularly where significant inequity exists. It is expected that activity to improve these measures will also improve results for the total population as the processes are universal with a focus on high risk groups.

5. ENABLERS TO CAPACITY AND CAPABILITY

ENABLERS TO CAPACITY AND CAPABILITY	
TRAINING AND EDUCATION	▪ SLM related Continuing Medical Education/ Continuing Nursing Education is filmed and shared regionally ▪ Health literacy improvement ▪ Auckland Regional HealthPathways ▪ Resources and key messages on various SLM work streams ▪ Planned communications of key messages at regular intervals.
DATA AND INFORMATION MANAGEMENT	▪ SLM data definitions, sourcing, analysis and reporting ▪ Ongoing use of the Metro Auckland Data Sharing Framework ▪ Increased use of data to inform implementation and improvement activities ▪ National Child Health Information Platform being rolled out in A/WDHB and Northland. Offers similar functionality to Kidzlink in CMH ▪ Advanced forms for improved data collection ▪ Commitment to equity view in data analysis and reporting, identifying areas for Māori and Pacific health gain.
SYSTEMS PARTNERSHIP	▪ Lead Maternity Carer (LMC) ▪ Well Child Tamariki Ora (WCTO) ▪ Auckland Regional Dental Services (ARDS) ▪ Immunisation Advisory Center (IMAC) ▪ Association with Auckland Regional Public Health Service (ARPHS) ▪ Pharmacy support ▪ Community laboratories ▪ Primary Care teams ▪ Secondary Care services ▪ Māori and Pacific providers ▪ Health navigators and health coaches ▪ School based health services.
QI SUPPORT	▪ Use of improvement methodologies underlying improvement activities ▪ Supported integration of cross-sectorial improvement activities.
CLINICAL LEADERSHIP	▪ Liaison with Metro Auckland Clinical Governance Forum ▪ Population health clinical leadership in planning and implementation.
CULTURAL LEADERSHIP	▪ Stepwise consultation and feedback huis with Māori and Pacific providers ▪ Support from Mana Whenua.

6. SYSTEM LEVEL MEASURES 2021/22 MILESTONES

Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population (on 2019 baseline) by 30 June 2022.** **6% reduction for Māori populations (on 2019 baseline) by 30 June 2022.** **6% reduction for Pacific populations (on 2019 baseline) by 30 June 2022.**

Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori populations (on 2019 baseline) by 30 June 2022.** **3% reduction for Pacific populations (on 2019 baseline) by 30 June 2022.**

Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: 80% (on February 2021 baseline) on Inpatient survey question:** *'Did those involved in your care ask you how to say your name if they were uncertain?'* **by 30 June 2022.** **Primary care survey: 5% relative improvement (on November 2020 baseline) on PES question:** : *'Do you have a shared treatment or care plan agreed with a health care professional to manage your condition(s)?'* **by 30 June 2022.**

Amenable Mortality	
System level outcome	Early detection and treatment
Improvement milestone	**3% annual reduction for each DHB (on 2017 baseline) until 30 June 2030.** **5% annual cumulative reduction for Māori under age 50 until 30 June 2030.** **3% annual cumulative reduction for Māori over age 50 until 30 June 2030.** **3% annual cumulative reduction for Pacific under age 50 until 30 June 2030.** **5% annual cumulative reduction for Pacific over age 50 until 30 June 2030.**

Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care
Improvement milestone	**Increase coverage of chlamydia testing in males aged 15-24 to 6% by 30 June 2022. (absolute values)**

Babies in Smokefree Homes	
System level outcome	Healthy start
Improvement milestone	**Increase the proportion of Māori babies living in smoke free homes by 2% by 30 June 2022. (on December 2020 baseline)**

7. IMPROVEMENT ACTIVITIES AND CONTRIBUTORY MEASURES

The following section outlines the specific improvement activity plan and contributory measures for the six SLMs for 2020/21. Improvement activities create change, improvement in contributory measures and contribute to improved outcomes in the various SLM milestones. For 2021/22, Auckland Metro region are focused on choosing activities which relate to multiple milestones where possible for best collective impact.

Ambulatory Sensitive Admissions in 0-4 year olds

Activities	Contributory Measure
Increase uptake of children's influenza vaccination to prevent respiratory admissions by: • Improving vaccination rates in primary care of children aged 0-4 years with previous respiratory admissions through the provision of data, practice-level improvement activities, and following up reporting of vaccination uptake provided throughout the season. • Prioritised vaccination of eligible Māori and Pacific children.	Influenza vaccination rates for eligible Māori children. Goal 30%. Influenza vaccination rates for eligible Pacific children. Goal 30%.
Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness leading to hospital admission by: • Develop a process to include primary care consultation in the data set to better understand where missed opportunities exist • Implementing the Best Start Pregnancy Tool so it can function as a pregnancy register in primary care. • Set primary care recalls for pregnant women to ensure they have developed a relationship with a midwife • Develop a process for making pertussis vaccination more readily available in primary care, including pharmacy	Influenza vaccine coverage rates for pregnant Māori. Goal 50%. Influenza vaccine coverage rates for pregnant Pacific. Goal 50%. Pertussis vaccine coverage rates for pregnant Māori. Goal 50%. Pertussis vaccine coverage rates for pregnant Pacific. Goal 50%.
Support a decrease in respiratory admissions with social determinants by: • Develop a baseline measurement of referrals to healthy housing with the aim of increasing referrals rates from primary care. • Prompt e-referral to Healthy Housing using Best Start Pregnancy, with a focus on pregnant, low income Māori and Pacific women. • Establish a baseline for referral of pregnant women who smoke for support to stop smoking when they visit general practice to confirm their pregnancy	

Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.

Youth Sexual and Reproductive Health

Activities	Contributory Measure
Improve young people manage their reproductive health safely and receive youth friendly care by: • Increasing engagement with young people by working with general practices and other youth healthcare providers to improve the youth friendliness of settings and enrolment rates. • Increasing sexual health screening by improving access to screening (including opportunistic) and screening for pregnant women. • Develop a process to include primary care consultation in the data set to better understand where missed opportunities exist • Monitoring consistency in and identifying barriers to accessing LARC in those under age 25 across Metro Auckland	Percentage of practices with at least one GP who has completed the RNZCGP 'Youth Friendly Audit' Goal: 3% relative improvement from 2021 baseline

Milestones: The Youth milestone will be improved by these activities.

Alcohol Harm Reduction

Activities	Contributory Measures
Improve data collection and reporting on alcohol harm reduction interventions through: • Establishment of an alcohol ABC baseline in primary care for reporting indicators. • Quality improvement activities focused on implementing Alcohol ABC in practice. • Improve data collection capability to multiple practice management systems	Percentage of enrolled population with an alcohol status recorded for patients aged 15 years and older within the last 3 years.

Milestones: The Amenable Mortality, Total Acute Hospital Bed Days and Youth milestones will be improved by these activities.

Smoking Cessation for Māori and Pacific

Activities	Contributory Measure
Patient outcomes related to harm from smoking will be improved by: • Regularly reporting rates of referrals received by cessation support providers and rates of cessation medication therapy prescribed in primary care, reported by ethnicity • Increase referrals to maternal smoking cessation incentives • Develop a surveillance report to monitor smoking prevalence by ethnicity and age. • Provide training and resources to practices on vaping to support smoking cessation	Rate of referral to smoking cessation providers reported by PHO and ethnicity. Goal: 6%. Rate of prescribing of smoking cessation medications reported by PHO and ethnicity. Goal 12%.

Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.

Cardiovascular Disease (CVD) Risk Assessment and Management

Activities	Contributory Measure
Primary care and systems partners work together to support equitable CVD Risk Assessment (RA) for Māori and Pacific by: • Provision of prioritised lists of eligible patients for risk assessment to practices, with Māori and Pacific first. • Monitor CVDRA Māori (2018 criteria) based on target 90%	Percentage of Māori with a previous CVD event that are prescribed triple therapy. Goal: 70%. Percentage of Māori with a CVD risk over 20% that are prescribed dual therapy. Goal: 60%
Improved outcomes for patients with a high risk of CVD event are sought by: • Patients who have previously had a CVD event and who are eligible receive the funded influenza vaccination. Monitored by DHB and ethnicity. Coverage will be monitored for the 65 – 74 year age group • Interventions to improve uptake of triple therapy for Māori	
Opportunities to improve data collection and quality are advanced through: • Development and baselines for a set of quality indicators to support the implementation of CVD consensus statement (with a focus on coding specified conditions e.g. IHD, AF, CKD, diabetes). • Fully implement the MoH CVD Risk Assessment Guidelines to include identification and recording of familial risk factors in primary care practice management systems and in reporting	

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

Babies in Smokefree Homes

Activities	Contributory Measure
The proportion of Māori babies living in smokefree homes will be increased by: • Promoting utilisation of the Best Start Pregnancy Assessment Tool in Primary Care • Referring pregnant smokers to cessation support services • Promoting smoking cessation incentives for pregnant smokers	Proportion of general practices utilising the Best Start Pregnancy Assessment Tool

Milestones: The Babies in Smokefree Homes, Ambulatory Sensitive Hospitalisation for 0-4 Year Olds, Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

Complex Conditions and Frail Elderly

Activities	Contributory Measures
Patients over age 65 receive influenza vaccination	Uptake of influenza vaccination by age and ethnicity
Increase referral of patients at high risk of falls to an appropriate Strength and Balance Falls Prevention Programme by: • PHOs to promote the uptake of falls prevention screening templates in all primary care patient management systems • Development of an updated Goodfellow Unit falls prevention webinar • DHBs to support contracted programme providers to engage directly at a general practice level to increase the profile of the falls prevention programme, prioritising practices with a high proportion of older people in their enrolled population	Falls screening in primary care completed within the last 12 months for Māori men and women age 55 and older Goal: 5% relative improvement on 2021 baseline Falls screening in primary care completed within the last 12 months for Pacific men and women age 55 and older Goal: 5% relative improvement on 2021 baseline Falls screening in primary care completed within the last 12 months for men and women of other ethnicities age 75 and older Goal: 5% relative improvement on 2021 baseline

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

Primary Options for Acute Care (POAC)

Activities	Contributory Measure
Primary and secondary care will work together with the POAC team to increase utilisation of POAC for high needs populations, particularly Māori and Pacific people aged 45-64 by: • Promotion of POAC and referral pathways within general practice to avoid acute ED presentations • Focusing on increasing utilisation of POAC for ASH conditions, particularly, CHF, COPD and cellulitis. • Develop regular reports for PHOs on POAC utilisation	POAC initiation rates in general practices for ASH Conditions

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

E-portals

Activities	Contributory Measure
Continued support for patient enrolment (logon) to e-portals by practices (given that unique email addresses are a critical dependency) by carrying out the following activities: • Receptionist training and socialisation. • Linking with practice accreditation processes. • Continuing to work with vendors to gain access to e-portal data	Percentage of each PHO's enrolled Māori and Pacific population with an email address on file with their general practice Goal: 30%

Milestones: The Patient Experience of Care milestone will be improved by these activities.

Patient Experience Surveys in Primary and Secondary Care

Activities	Contributory Measure
Primary care will improve patient experience by: • Working with early adopter practices to champion engagement. • Prioritising feedback from Māori and Pacific patients. • Participating in CQI activity via 'PES to PDSA' or 'You said – We did activity/Kōrero mai'. • Developing a PDSA activity focussed on Māori and Pacific. • PHO to practice support continues in monitoring and managing reports post survey week. • Practices utilise feedback from patients and whānau when making changes in the practice. • Develop processes for measuring percentage of valid email addresses	Average score in primary care question: *'Do you have a shared treatment or care plan agreed with a health care professional to manage your condition(s)?'*
Secondary care will improve patient experience by: • Focusing on the medication safety question in the National Inpatient Survey with a multidisciplinary approach. • Create training package in conjunction with a Health Psychologist for all hospital pharmacists and student pharmacists with links to patient experience, multidisciplinary team relationships, framing and communication approaches. • Development of Health Navigator resources and online resources. • Development of an acute pain management discharge checklist. • Testing of electronic solutions via Medchart to prompt patient conversations • Focusing on culturally appropriate. patient centred engagement and information • Sharing learnings with primary care through established networks and forums. Improving visibility of reporting of Māori and Pacific response rates, with a view to encouraging awareness via activities as noted above. Primary and secondary care will work together to explore the underlying data for Māori and Pacific patients enrolled in primary care to identify barriers to participations in the PHC PES.	Average score in Inpatient survey question: 'Did those involved in your care ask you how to say your name if they were uncertain?'

Milestones: The Patient Experience of Care milestone will be improved by these activities.

8. SYSTEM LEVEL MEASURE MILESTONES IN DETAIL

8.1 Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds

System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population by 30 June 2021.** **3% reduction for Māori populations by 30 June 2021.** **3% reduction for Pacific populations by 30 June 2021.**

This section reflects performance in the current plan year and in some cases may differ from the above, based on changes made to promote continuous quality improvement. Ambulatory sensitive hospitalisations are admissions considered potentially preventable through pre-emptive or therapeutic interventions in primary care. The admissions included are made up of a specified set of discharge codes considered to be ambulatory sensitive, and are assigned based on the primary diagnosis. This is a challenging indicator as social determinants of health are a significant contributor. The amount realistically amenable to timely access to quality primary care has not been quantified and there is little evidence about what works outside of immunisation for vaccine preventable diseases. Despite these challenges there are many promising approaches.

In addition to paediatric and maternal immunisation, smoking cessation and improving the housing environment are important for improving this milestone. This year we have chosen to focus on these aspects of the Child and Adolescent Asthma Guidelines, fitting with a broader focus on respiratory admissions, which is the largest contributor to Ambulatory Sensitive Hospitalisations in 0-4 across the three DHBs.

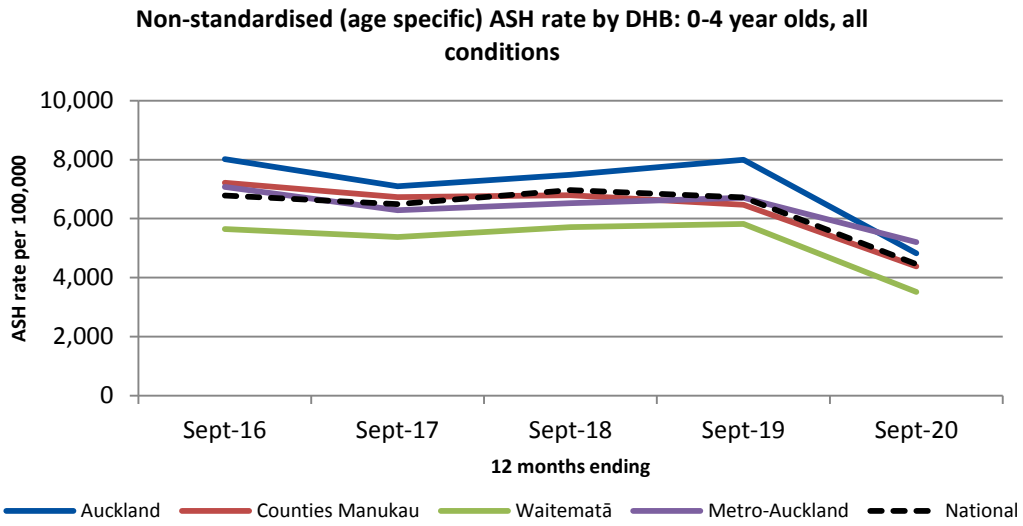
We plan to build on improvements in immunisation rates and spread the methodology to other high risk cohorts which will improve outcomes in acute hospital bed days.

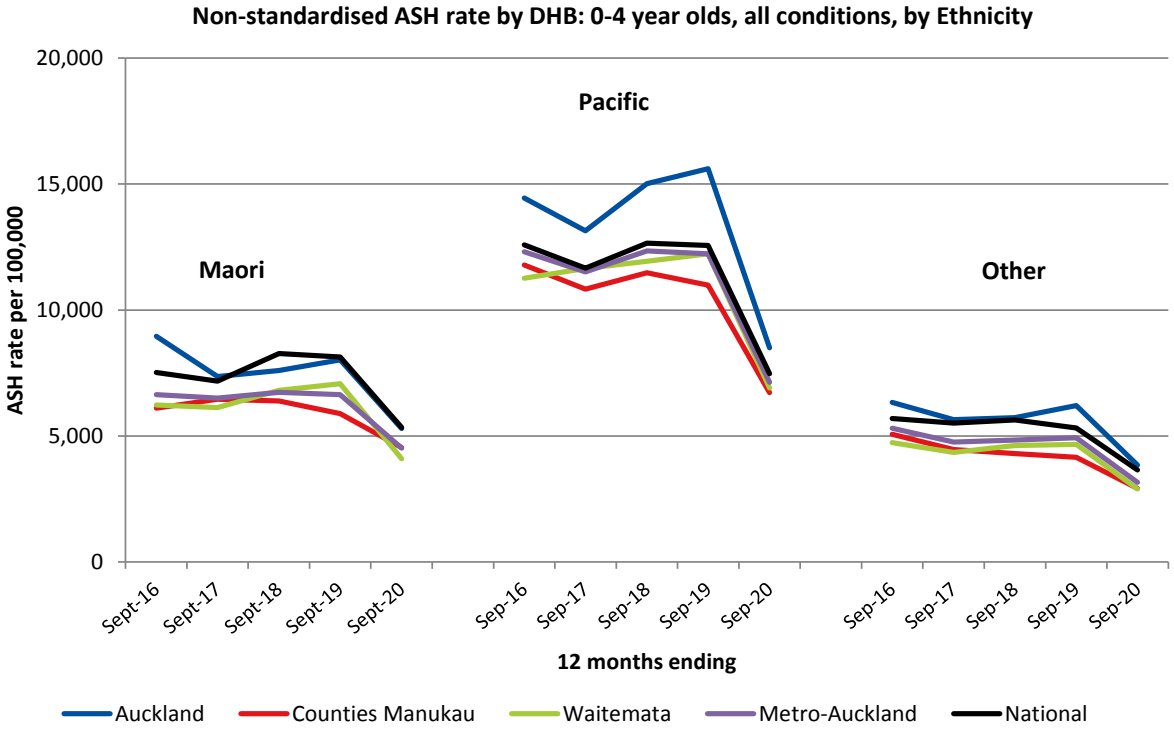
This year we aim to continue our focus on equity with an improvement for Māori and Pacific rates.

ASH rates per 100,000 for 0–4 year olds

Improvement Milestone: 3% reduction (on Dec-19 baseline) (by ethnicity) by 30 June 2021

	Milestone Target			**Actual – 12 months to September 2020**		
	Auckland	Counties Manukau	Waitematā	Auckland	Counties Manukau	Waitematā
Total pop.	7,749	6,062	5,727	4,822	4,380	3,511
Māori	8,155	5,421	7,170	5,294	4,539	4,095
Pacific	14,391	10,440	11,510	8,505	6,721	6,904


Non-standardised (age specific) ASH rate by DHB: 0-4 year olds, all conditions
10,000
8,000
6,000
4,000
2,000
0
ASH rate per 100,000
Sept-16
Sept-17
Sept-18
Sept-19
Sept-20
12 months ending
Auckland
Counties Manukau
Waitematā
Metro-Auckland
National


Non-standardised ASH rate by DHB: 0-4 year olds, all conditions, by Ethnicity
20,000
15,000
10,000
5,000
0
ASH rate per 100,000
Maori
Pacific
Other
Sept-16
Sept-17
Sept-18
Sept-19
Sept-20
Sep-16
Sep-17
Sep-18
Sep-19
Sep-20
12 months ending
Auckland
Counties Manukau
Waitemata
Metro-Auckland
National

8.2 Total Acute Hospital Bed Days

System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori population by 30 June 2021.** **3% reduction for Pacific population by 30 June 2021.**

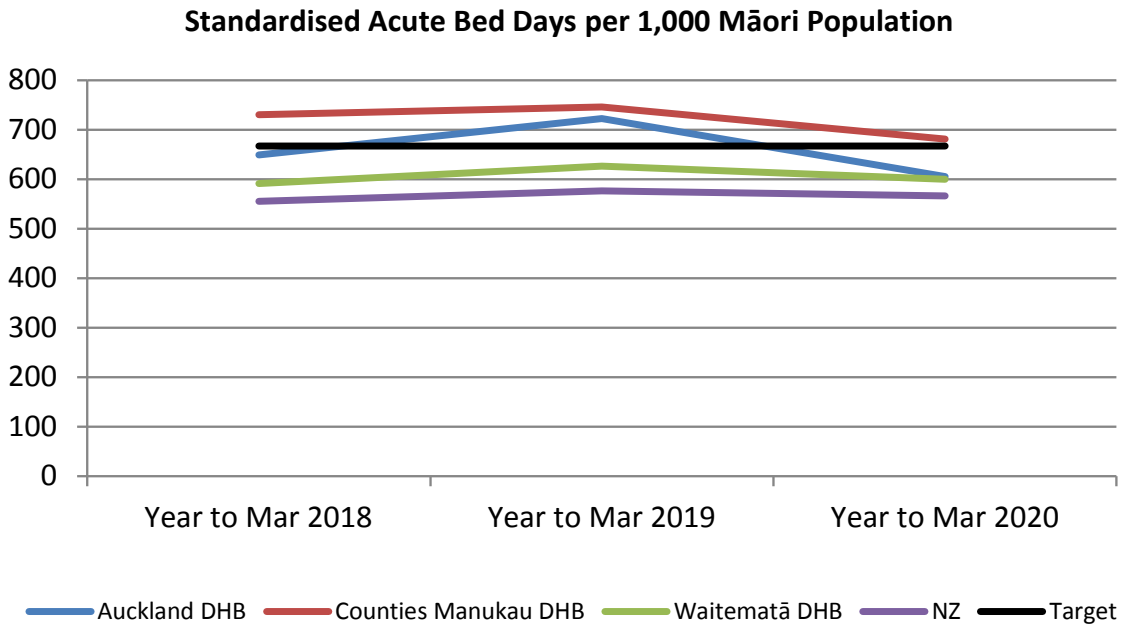
Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. The intent of the measure is to reflect integration between community, primary and secondary care, and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care. We will achieve a greater reduction in acute bed days for higher risk populations via targeted initiatives to improve the health status of Māori and Pacific peoples in particular. Specific targets for these populations are higher due to the inequity when compared to the total population.

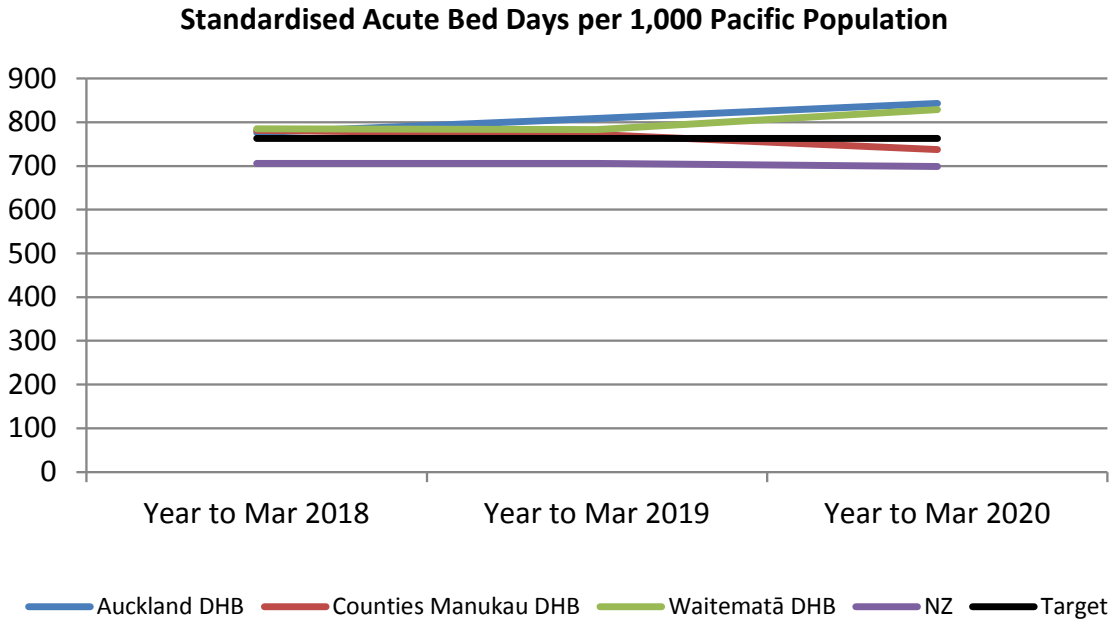
We plan to target populations most likely to be admitted or readmitted to hospital, and focus on prevention and treatment of conditions that contribute the most to acute hospital bed days. Priority areas include alcohol harm reduction, CVD management, influenza vaccination for high risk groups and effective use of POAC. Conditions identified as highest priority include congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Coding for these conditions in primary care will be improved so effective interventions can be targeted. Total acute hospital bed days for 2019/20 for Māori and Pacific identify marked inequities when compared to non-Māori, non-Pacific rates, so we will continue to focus on patients from this population in addition to the prioritised conditions.

Total acute hospital bed days

Improvement Milestone: 3% reduction (on Dec-19 baseline) for Māori and Pacific population by 30 June 2021 (standardised)

	Milestone Target			**Actual – 12 months to September 2020 (latest available)**		
	Auckland	Counties Manukau	Waitematā	Auckland	Counties Manukau	Waitematā
Māori	623	686	567	566	610	542
Pacific	809	718	791	729	655	789





8.3 Patient Experience of Care

System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: 5% relative improvement (on Spring 2020 baseline) on Inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with in a way you could understand?' by 30 June 2021.** **Primary care survey: 5% relative improvement (on Spring 2020 baseline)on PES question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?' by 30 June 2021.**

Patient experience is a good indicator of the quality of health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes. The

Health Quality and Safety Commission (HQSC) patient experience survey (PES) domains cover key aspects of a patient's experience when interacting with health care services: communication, partnership, coordination, and physical and emotional needs. Performance across all three Metro Auckland DHBs is above 90% for the first three quarters of the 2020/21 plan year.
The 2021/22 plan continues to look at performance of individual questions rather than response rates to the survey.
The patient experience surveys have been significantly disrupted during 2019/20 with:

- A refresh of the survey precluding direct comparison of questions between the old and new surveys
- A change in provider contributing to a pause in delivery of the survey and discontinuous data flow
- The Covid-19 crisis which further contributed to pausing the survey and also resulted in a significant changes in the way patients accessed primary care

Hospital Inpatient PES: The medication side effect question has been modified for the recent inpatient survey. At the time of submission of this plan data was not available for the modified question. It is highly likely that the communication of medication information will continue to be an area for improvement for the total population and also for Māori.
The milestone for 2020/21 will continue to focus on the knowledge patients have about possible medication side effects when they are discharged from hospital. This will be achieved by education of multidisciplinary teams focusing on patient empowerment, health literacy, and equity. A baseline will be established and improved upon when the first survey is conducted using the new survey.

Hospital Inpatient survey – percentage of respondents who answered 'yes, completely', to the inpatient survey question: 'Were you told the possible side effects of the medicine (or prescription for medicine) you left hospital with, in a way you could understand?'

2020/21 Targets			
Auckland DHB	**Counties Manukau DHB**	**Waitematā DHB**	**Metro-Auckland**
49.7%	61.8%	47.0%	49.4%
Results: % of 'yes, completely' result			
DHB	**Q1 2020/21**	**Q2 2020/21**	**Trend**
Auckland DHB	60.9%	66.3%	↑
Counties Manukau DHB	63.0%	61.5%	↓
Waitematā DHB	63.2%	59.0%	↓
Metro-Auckland	62.7%	61.2%	↓

Primary Health Care PES: The PHC PES is also well established in primary care. In keeping with the aim of reducing inequality the question about individual or cultural needs was chosen. This question has been introduced in the new survey and again a baseline will be established with the first round of the survey. Patient feedback and PDSA improvement cycles will lead to changes in practices that are important to patients and will promote cultural safety and improved engagement.

Primary health care patient experience survey – percentage of respondents who answered 'yes, completely', to the survey question: 'During this (consult/visit), did you feel your individual and/or cultural needs were met?'

2020/21 Targets			
Auckland DHB	**Counties Manukau DHB**	**Waitematā DHB**	**Metro-Auckland**
98.2%	96.6%	100%	98.1%
Results: % of 'yes, completely' result			
DHB	**Q1 2020/21 (Baseline)**	**Q2 2020/21**	**Trend**
Auckland DHB	93.5%	93.0%	↓
Counties Manukau DHB	92.0%	90.7%	↓
Waitematā DHB	95.9%	93.3%	↓
Metro-Auckland	93.5%	92.4%	↓

None of the 3 Metro Auckland DHBs has achieved 5% relative improvement from the baseline for the new question, however, all performance was above 90% for all three DHBs.

8.4 Amenable Mortality

System level outcome	Preventing and detecting disease early
Improvement milestone	**6% reduction for each DHB (on 2013 baseline) by 30 June 2021.** **2% reduction for Māori and Pacific by 30 June 2021.**

Two contributory measures have been consistent in amenable mortality improvement planning to date, those that have the greatest evidence-based impact – cardiovascular disease (CVD) management and smoking cessation.

CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD. Patients with established CVD (and those assessed to be at high CVD risk) are at very high risk of coronary, cerebral and peripheral vascular events and death, and should be the top priority for prevention efforts in clinical practice.

In 2021/22 we aim to build on the work done in implementation of the new Consensus Statement for Assessment and Management of CVD. With the risk assessment algorithms available to primary care there will be a stronger emphasis on risk assessment for Māori and primary prevention for those at greatest risk. We continue to focus on secondary prevention for this population.

Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and tobacco availability to minimal levels, essentially making New Zealand a smoke-free nation by 2025. In 2013, 15% of New Zealanders smoked tobacco every day. That rate was even higher among Māori (33%) and Pacific people (23%). Differences continue to be evident in the prevalence of smoking between the three ethnicity groupings of European/Other, Māori and Pacific.

Through the use of data sharing we can focus on referrals to smoking cessation services by practitioners in different parts of the health system.

The 2021/22 plan will build on the successful implementation of the Alcohol ABC programme. This is an evidence based programme to decrease harm from excessive alcohol consumption.

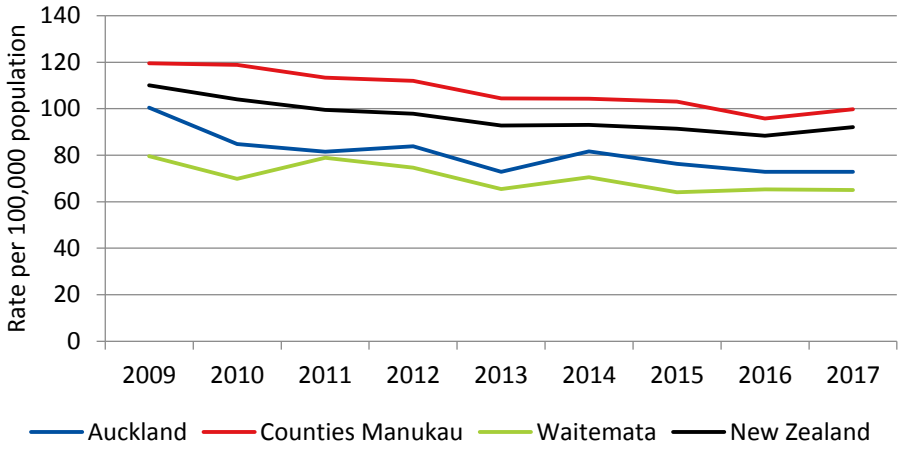
Amenable mortality

Improvement milestone 6% reduction for each DHB (on 2013 baseline) by 30 June 2021.

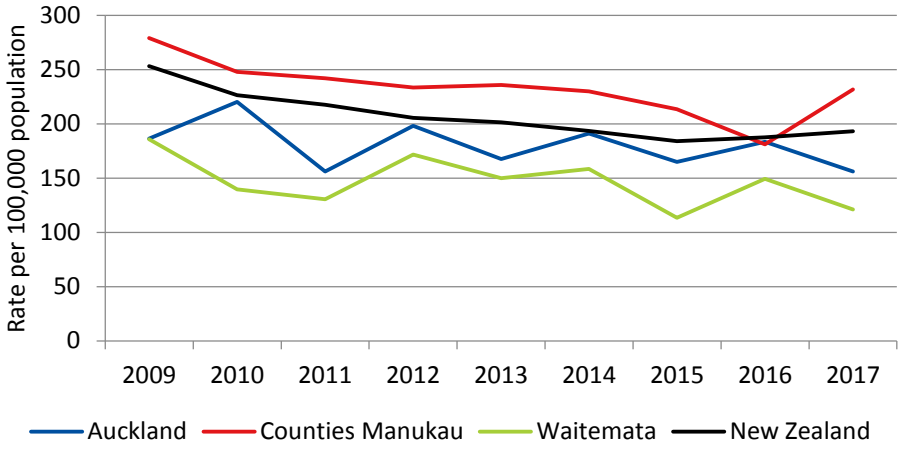
2% reduction for Māori and Pacific by 30 June 2021.

	Milestone Target			**Actual – 2017 deaths**		
	Auckland DHB	Counties Manukau DHB	Waitematā DHB	Auckland DHB	Counties Manukau DHB	Waitematā DHB
Total Pop	68.5	98.1	61.5	72.8	99.8	65.0
Māori	179.9	177.4	146.3	156.1	231.7	121.1
Pacific	150.1	180.9	150.5	177.1	170.5	142.3

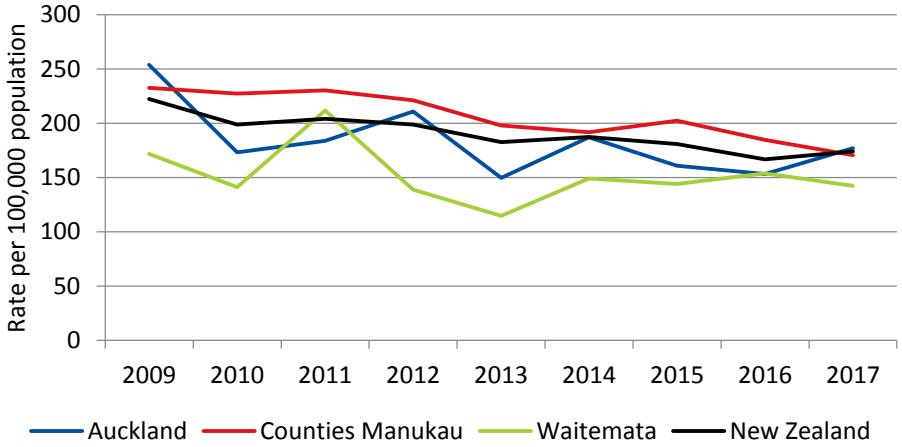
Amenable mortality age standardised rates 0-74 year olds 2009-2017



Amenable mortality age standardised rates 0-74 year old Māori 2009-2017



Amenable mortality age standardised rates 0-74 year old Pacific 2009-2017



8.5 Youth Access to and Utilisation of Youth-appropriate Health Services

System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care
Improvement milestone	**Increase coverage of chlamydia testing in youth aged 15-24 to 6% by 30 June 2021. (on 2019 baseline)**

Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth whose healthcare needs are unmet may progress to adults with an increased risk for poor health and overall poor life outcomes through disengagement and isolation from society and riskier behaviors, in terms of drug and alcohol abuse and criminal activities.

Chlamydia testing coverage: This is an indicator of young people's access to confidential youth appropriate comprehensive healthcare. For those young people 15-24 years who have been, or are sexually active, access to chlamydia testing is an indicator of access to condoms, contraceptives, and to a discussion with a clinician about consent, sexuality and other harm minimisation. For some young people this may mean addressing their safety, unmet mental health needs, or alcohol and drug problem.

Chlamydia is the most commonly reported sexually transmitted infection in Auckland. It is most often diagnosed in females aged 15-19 years and in males aged 20–24 years. Māori and Pacific young people have substantially higher rates of chlamydia than non-Māori non Pacific youth. In addition, when tested, males are more likely to test positive, although this may be because they are only presenting when they have symptoms. In the UK, data from the youth screening programme shows that more than 50% of 16–24 years olds with chlamydia have no or non-specific symptoms. For testing coverage to be effective in reducing the prevalence of chlamydia it needs to target those who have the highest risk of infection, namely males, and Māori and Pacific youth of either gender. While we aim to increase screening rates for all youth there is a focus on improving rates for males.

Chlamydia testing coverage in 15-24 year old males

Improvement milestone: increase coverage of chlamydia testing for males to 6% for 15-24 year olds by June 2021.

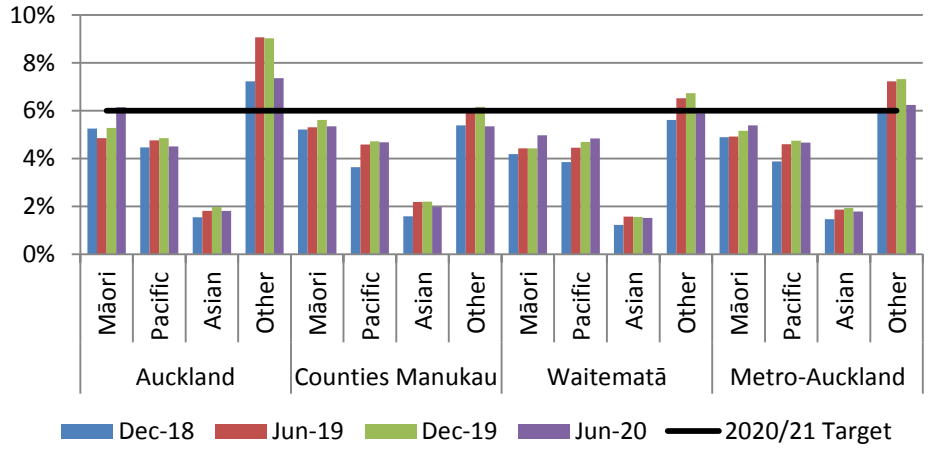
Results for the 6 month period to June 2020 (latest available): males only – note this is at a population level (so may include males in this age group who are un-enrolled in a PHO).

DHB	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	June 2020 Chlamydia test rate (%)	December 2019 Chlamydia test rate (%)	Change
Auckland	Māori	233	3790	**6.1%**	**5.3%**	↑
	Pacific	232	5150	**4.5%**	**4.9%**	↓
	Asian	256	14210	**1.8%**	**2.0%**	↓
	Other	1089	14790	**7.4%**	**9.0%**	↓

Counties Manukau	Māori	461	8630	**5.3%**	**5.6%**	↓
	Pacific	566	12120	**4.7%**	**4.7%**	-
	Asian	235	11920	**2.0%**	**2.2%**	↓
	Other	570	10670	**5.3%**	**6.2%**	↓
Waitematā	Māori	296	5960	**5.0%**	**4.4%**	↑
	Pacific	208	4300	**4.8%**	**4.7%**	↑
	Asian	157	10330	**1.5%**	**1.5%**	-
	Other	1247	21170	**5.9%**	**6.7%**	↓
Metro-Auckland	Māori	990	18380	**5.4%**	**5.2%**	↑
	Pacific	1006	21570	**4.7%**	**4.7%**	-
	Asian	648	36460	**1.8%**	**1.9%**	↓
	Other	2906	46630	**6.2%**	**7.3%**	↓

* 10 with unknown gender excluded

Chlamydia test rate for males aged 15-24 years at population level by DHB, prioritised ethnicity



Current results – at PHO enrolled population level:

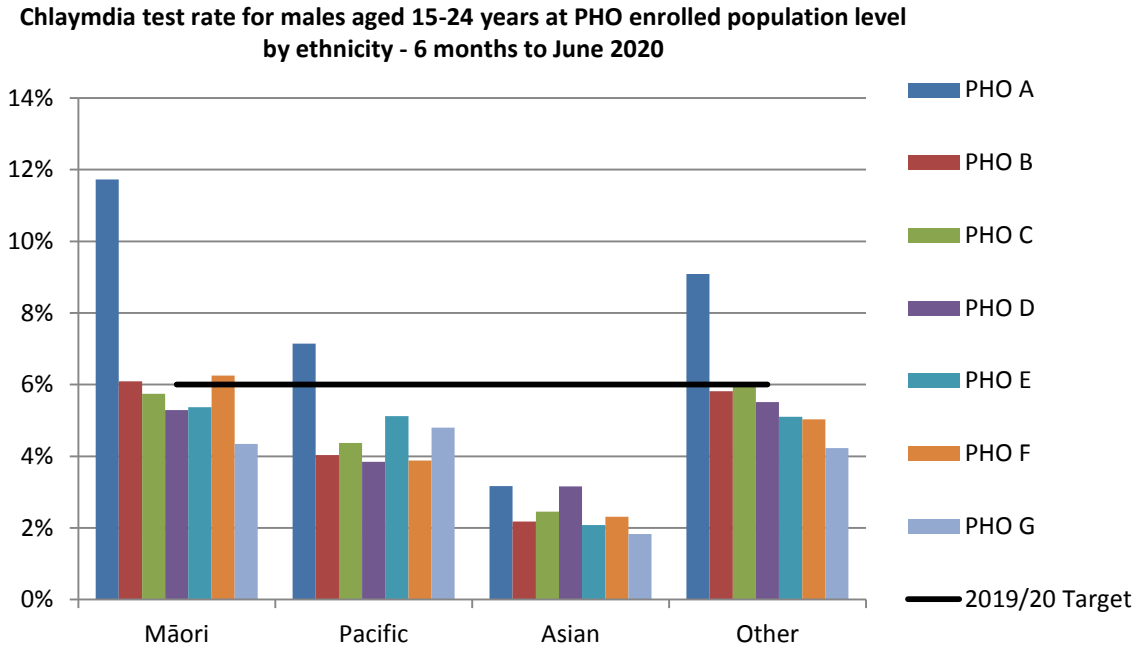
Results at this level, although better, have generally decreased between reporting periods. Again, this is probably due to the impact of COVID-19 on primary care services as well as access behaviour, particularly over the lockdown periods.

The differences between this level and population level coverage rates suggests that there is under-enrolment for this cohort of the population.

Results at June 2020 compared to December 2019 (2019/20 target 6%):

PHO	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	June 2020 Chlamydia test rate (%)	December 2019 Chlamydia test rate (%)	Change
PHO A	Māori	34	290	11.7%	9.0%	↑
	Pacific	26	364	7.1%	9.8%	↓
	Asian	35	1,104	3.2%	3.8%	↓
	Other	112	1,232	9.1%	9.7%	↓
PHO B	Māori	86	1,411	6.1%	6.2%	↓
	Pacific	61	1,513	4.0%	3.6%	↑
	Asian	49	2,250	2.2%	2.7%	↓
	Other	109	1,875	5.8%	7.6%	↓
PHO C	Māori	402	7,004	5.7%	6.2%	↓
	Pacific	367	8,405	4.4%	4.4%	-
	Asian	240	9,765	2.5%	2.6%	↓
	Other	1,512	25,105	6.0%	6.6%	↓
PHO D	Māori	74	1,398	5.3%	5.8%	↓
	Pacific	134	3,485	3.8%	4.4%	↓
	Asian	53	1,676	3.2%	3.3%	↓
	Other	107	1,942	5.5%	6.2%	↓
PHO E	Māori	61	1,136	5.4%	6.6%	↓
	Pacific	28	547	5.1%	4.9%	↑
	Asian	37	1,780	2.1%	2.3%	↓
	Other	410	8,042	5.1%	5.8%	↓
PHO F	Māori	161	2,576	6.3%	6.9%	↓
	Pacific	255	6,572	3.9%	4.0%	↓
	Asian	76	3,287	2.3%	2.3%	-
	Other	71	1,412	5.0%	4.3%	↑
PHO G	Māori	14	322	4.3%	6.1%	↓
	Pacific	7	146	4.8%	4.9%	↓

PHO	Ethnicity	No. of males 15-24 years having chlamydia tests	Population	June 2020 Chlamydia test rate (%)	December 2019 Chlamydia test rate (%)	Change
	Asian	26	1,418	1.8%	1.9%	↓
	Other	137	3,240	4.2%	4.1%	↑



8.6 Babies in Smokefree Homes

System level outcome	Healthy start
Improvement milestone	**Increase the proportion of babies living in smokefree homes by 2% by 30 June 2021**

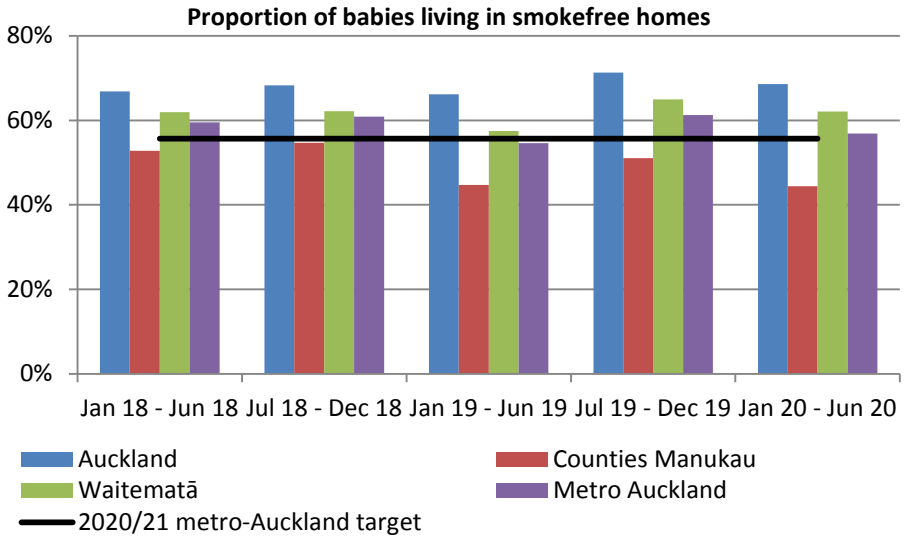
The definition of a smoke-free household is one where no person ordinarily resident in the home is a current smoker. This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy, to birth, to the home environment within which they will initially be raised. Of note, smoking during pregnancy and exposure to tobacco smoke in infancy is highest for Māori and Pacific.

Proportion of babies who live in a smoke-free household at six weeks post-natal

Improvement milestone: Increase the proportion of babies living in smokefree homes by 2% (Jan 19 – Jun 19 baseline)

Reporting period	DHB of domicile			
	Metro-Auckland	Auckland	Counties Manukau	Waitematā

Jan 18 - Jun 18	59.5%	66.8%	52.8%	61.9%
Jul 18 – Dec 18	60.9%	68.3%	54.7%	62.2%
Jan 19 - Jun 19	54.6%	66.2%	44.7%	57.5%
Jul 19 – Dec 19	61.2%	71.3%	51.1%	64.9%
Jan 20 – Jun 20	56.9%	68.6%	44.4%	62.1%
2020/21 Targets	**55.7%**	**67.5%**	**45.6%**	**58.6%**

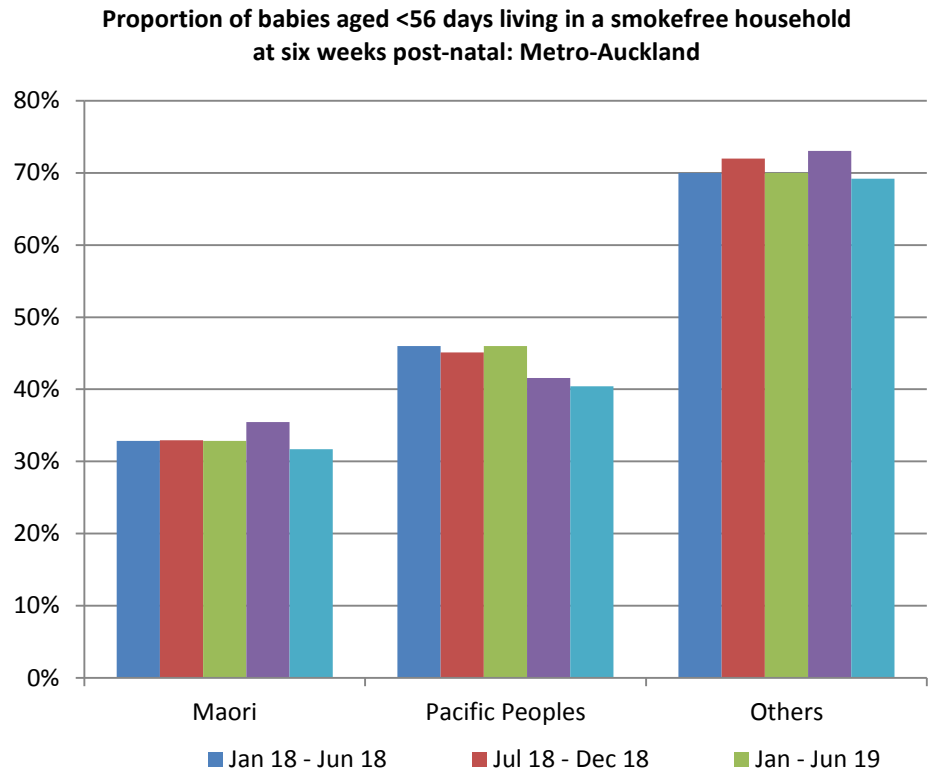


The release of this data from the Ministry of Health has been sporadic and delayed and the methodology for calculating the measure has changed three times. The data from January 2018 uses the latest methodology. Results show that only Counties Manukau DHB is not reaching the DHB's individual target and performance has declined since the last reporting period for all DHBs.

This measure aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy to birth and the home environment within which they will initially be raised.

Data is sourced from Well Child Tamariki Ora providers and shows that around 56% of metro-Auckland babies live in a smokefree household at 6 weeks post-partum with a small improvement since the Jan-Jun 2019 reporting period.

The percentage of Māori babies living in smokefree homes is much lower than other ethnicities - 22% in Counties Manukau DHB, 39% in Waitematā DHB and 45% in Auckland DHB. Rates for Pacific are also lower than other ethnicities. Rates for all ethnicities have declined since the previous reporting period. While higher rates correlate with rates of smoking in pregnancy, and general smoking, in Māori and Pacific populations, there would also have been some impact from COVID-19 on this indicator.



Fewer Māori babies live in smokefree homes. Rates for Pacific are also lower than other ethnicities. This correlates with rates of smoking in pregnancy, and general smoking, in Māori and Pacific populations.

Our work will be supported by earlier identification of smoking in pregnancy and referral to services for pregnant women and their whānau.

9. GLOSSARY

ABC	Assessment, Brief Advice, and Cessation Support
ADHB	Auckland District Health Board
AF	Atrial Fibrillation
ARDS	Auckland Regional Dental Service
ARPHS	Auckland Regional Public Health Service
ASH	Ambulatory Sensitive Hospitalisations
A/WDHB	Auckland Waitemata District Health Boards
CHF	Coronary Heart Failure
CKD	Chronic Kidney Disease
CME/CNE	Continuing Medical Education/Continuing Nursing Education
CMH	Counties Manukau Health (referring to Counties Manukau District Health Board)
COPD	Chronic Obstructive Pulmonary Disorder
CVD	Cardiovascular Disease
CVD RA	Cardiovascular Disease Risk Assessment
DHB	District Health Board
ED	Emergency Department
GP	General Practice/General Practitioner
HQSC	Health Quality Safety Commission
IHD	Ischaemic Heart Disease
IMAC	Immunisation Advisory Center
LMC	Lead Maternity Carer
MACGF	Metro Auckland Clinical Governance Forum
MADSF	Metro Auckland Data Sharing Framework
PDSA	Plan, Do, Study, Act
PES	Patient Experience Survey
PHC PES	Primary Healthcare Patient Experience Survey
PHO	Primary Healthcare Organisation
PMS	Practice Management Systems
POAC	Primary Options for Acute Care
SLM	System Level Measure
SMI	Serious Mental Illness (refers to schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder as per the National Consensus Statement for Risk Assessment and Management of CVD in Primary Care)
STI	Sexually Transmitted Infection
UK	United Kingdom
WDHB	Waitemata District Health Board
WCTO	Well Child Tamariki Ora